Registered Nurse, Mr B

Registered Nurse, Ms C

Registered Nurse, Ms E

Registered Nurse, Ms D

Registered Nurse, Ms G

General Practitioner, Dr F

A Report by the

Health and Disability Commissioner

(Case 02HDC08905)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A (deceased)	Consumer
Executors of the Estate of Mrs A	Complainants
Mr B	Provider / Registered Nurse Director of the nursing agency (in liquidation)
Ms C	Provider / Registered Nurse
Ms D	Provider / Registered Nurse
Ms E	Provider / Registered Nurse
Dr F	Provider / General Practitioner
Ms G	Provider / Enrolled Nurse
Mr H	Property Manager
Mr I (deceased)	Property Manager
Mr J	Welfare Guardian
Ms K	Caregiver
Ms L	Caregiver
Ms M	Caregiver
Ms N	Caregiver
Dr O	Consultant Geriatrician
Dr P	Consultant Geriatrician
Dr Q	Haematologist
Dr R	Palliative Care Specialist
Ms S	Wound Care Specialist
Ms T	Caregiver

Complaint

On 28 June 2002 the Commissioner received a complaint from the executors of the Estate of Mrs A, about services provided to Mrs A while she was being cared for in her home. The complaint was summarised as follows:

From 17 August 2000 to 19 November 2001, registered nurse Mr B did not provide services of an appropriate standard to Mrs A. In particular Mr B:

- *did not take adequate measures to prevent Mrs A from developing pressure sores and foot ulcers*
- *did not adequately manage Mrs A's pressure sores and foot ulcers.*

An investigation was commenced on 4 November 2002. On 7 May 2003, the investigation was extended to include the services provided by Dr F, general practitioner; Ms C and Ms D, registered nurses; and Ms G, enrolled nurse, in respect of these issues. On 6 June 2003 the investigation was further extended to include the services provided by Ms E, registered nurse.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information reviewed

- The public hospital records for Mrs A
- Nursing notes from the nursing agency

Independent expert advice was obtained from the following advisors:
- Dr Tessa Turnbull, general practitioner
- Ms Jenny Eastgate, nurse consultant
- Ms Jenny Phillips, nurse practitioner (wound care)
- Dr Ken Thomson, forensic pathologist

Clarification of Commissioner's role

The role of the Health and Disability Commissioner under section 35 of the Health and Disability Commissioner Act 1994 is to investigate any action of any health care provider where that action is, or appears to be, in breach of the Code of Health and Disability Services Consumers' Rights (the Code). In relation to Mrs A's care and the complaint made by the executors of her Estate, the primary focus of my investigation has been whether the care provided to Mrs A was of an appropriate standard as required by Right 4 of the Code.

I appreciate that the difficulties that arose between Mrs A's welfare guardian and property managers impacted on the decisions made for Mrs A in relation to where she was to live and who would provide care for her. Ultimately, as is clearly set out in the orders made under the Protection of Personal and Property Rights Act 1988 (PPPR Act)[1], those decisions fell to the welfare guardian Mr J.[2] It is not within my jurisdiction to consider the decisions made by Mr J in his role of welfare guardian.

Information gathered during investigation

Overview
Mrs A was an elderly woman who lived alone and independently in her apartment until she developed dementia and mobility problems. When Mrs A's mobility problems worsened early in 2000, she was reluctantly hospitalised. Following a court hearing in August 2000, two property managers and a welfare guardian were appointed to manage her affairs. Arrangements were subsequently made for Mrs A's hospital discharge into the care of a nursing agency, who were to provide 24-hour nursing services in her home. The nursing

[1] PPPR case, reserved judgment, Auckland, August 2000.
[2] Under section 20 of the PPPR Act 1988, welfare guardians are not liable provided that they act within their prescribed powers, unless shown to have acted in bad faith or without reasonable care.

agency was informed that Mrs A presented as a particularly challenging nursing assignment, due to aspects of her medical condition combined with her demanding and challenging behaviour.

The nursing agency cared for Mrs A at home during the 15-month period from 14 August 2000 until her death. Mr B was the company director of the nursing agency, and was also a registered nurse who had direct involvement in Mrs A's nursing care. The nursing agency employed a number of registered nurses, an enrolled nurse, and a team of caregivers who were rostered on shifts to care for Mrs A. During the latter half of 2001, Mrs A developed several pressure sores on her sacral and gluteal areas, one of which became necrotic and was particularly extensive. Mrs A also developed ulcers on her feet over an uncertain period. Evidence gathered during my investigation revealed that progressive cutbacks in the numbers and skill level of staff caring for Mrs A occurred during her time at home with the nursing agency.

A complaint was made to my Office by the executors of Mrs A's estate. Post-mortem photographs showing Mrs A's pressure sores and foot ulcers were supplied, along with a report by the embalmer describing the overall condition of Mrs A's body. This report concluded: "While Decubitis ulcers are a common occurrence in embalming [Mrs A's] ulcers were more significant than those I and my colleagues have previously encountered in our experience as embalmers." Allegations of severe neglect were made.

Background to the public hospital admission
On 17 March 2000, Mrs A, then aged 83 years, was admitted to the public hospital with problems including a diagnosis of frontal lobe vascular dementia, and problems with her mobility.

Prior to her hospital admission, Mrs A had been living alone in her city apartment. She had come to the city from an overseas country in December 1999, and previously had travelled regularly between her overseas and city residences. She had no surviving close family members, but had ongoing contact with a number of friends and personal advisors based in the city or overseas.

Dr P, a consultant geriatrician at the public hospital's "Older Person's Health", visited Mrs A at home on 16 March 2000 in response to the urgent request of a community social worker. The social worker had been contacted by a friend and ex-neighbour of Mrs A, Mr J, who had been visiting Mrs A and attempting to care for her in her home. Mr J advised the social worker that Mrs A had had several falls in the last few days.

According to Dr P, Mrs A was immobile and incontinent, having to urinate into a towel between her legs when he visited. He advised me that Mrs A's dementia prevented her from realising the plight she was in. His record of 16 March 2000 states:

> "Visited [at] home. 2¼ hour [visit]! (eccentric [and] irrational). [Mrs A] has a very difficult personality [at] present – may be an emotional response to the major physical disability she has. At present she cannot move from her chair because of back [and right] knee pain [and] severe weakness of the [right] quads. At the beginning of the interview

> she was forcefully and adamantly positive that she would not be admitted to hospital for assessment and rehab. However we finally agreed that it was the only logical solution to her problems and she agreed to admission tomorrow [morning]."

Mrs A was admitted to the public hospital the following day. Dr P advised me that in order to prevent her from carrying out a threat to discharge herself prematurely, it was necessary to take out a temporary personal order under the Protection of Personal and Property Rights Act 1988 (PPPR). He explained: "This required her to remain in hospital until her medical attendants judged that she was ready for discharge and could arrange suitable follow-up care for her."

The public hospital – eccentric personality; behaviour and medical problems

In the event, Mrs A remained in the public hospital for five months, from 17 March to 14 August 2000. It was a difficult hospital stay. Dr O, another consultant geriatrician who was involved in Mrs A's care from the time of her admission, provided details about her background and her hospital stay in a discharge letter dated 13 August 2000:

> "[Mrs A] is reported to have been an astute business person. … She has been a very strong minded person, used to having her own way. At her best she is a winsome and witty conversationalist but at her worst has no hesitation in verbally abusing those who try to care for her. … Over the past two years at least she has deteriorated mentally. Friends noticing that she is less sharp intellectually, tending to repeat herself, lose the thread of conversation and perhaps as a result has become more demanding and abusive. She has been extraordinarily demanding in hospital, at times pleasant and witty but most of the time shouting instructions and abuse at the top of her voice, slapping nurses, turning the television up to full volume to attract attention …"

Aside from problems associated with Mrs A's behaviour and dementia, another significant problem was her continued lack of mobility. In his letter of 13 August 2000, Dr O noted that this had been the primary reason for her admission. He further noted that Mrs A's mobility problems were multifactorial in origin, relating to "steroid myopathy [steroid-induced muscle weakness], osteoarthritis of her right hip and a fear of falling". Apraxia of gait related to her dementia was another possible contributing factor.

In addition to these problems, Mrs A's medical history included idiopathic thrombocytopenic purpura (ITP – a condition causing low blood platelets and bleeding), for which Mrs A had been treated for a number of years by haematologists, and was the reason she was on steroids.

Mrs A also had a history of vascular insufficiency and had once previously had an ischaemic ulcer, as reported by a haematology registrar in 1996.

Discharge planning – Order under PPPR Act

To ensure Mrs A's safe discharge from the public hospital, a series of arrangements were necessary. Dr O advised me that a number of difficulties needed to be overcome to ensure the appropriate arrangements were made. As he explained in his discharge letter of 13 August 2000:

> "[Mrs A] is an [overseas] national but 'non resident' and normally spends several months a year in her apartment [in a New Zealand city]. She was adamant that she wished to return to her apartment but it was evident to us that with her immobility, she would be at grave risk from falling and fracture and self neglect. … most importantly she refused to agree to the 24 hour nursing care that would be required to keep her safely at home. … In a meeting with all her friends it was decided to apply for a Welfare Guardian and Property Manager on the grounds that she lacks mental competence to manage her personal care and finances, and finally a court hearing in August 2000 under [a judge] led to [Mr J] becoming Welfare Guardian and [Mr H] (personal financial advisor) and [Mr I] (bank manager and friend) being appointed property managers."

This was a permanent order replacing the temporary one that had required Mrs A to remain at the public hospital pending satisfactory discharge arrangements. At the court hearing, it was noted that despite her initial resistance to the idea that she would require full-time care in order to be discharged, Mrs A did eventually come to acknowledge the need for this. During the hearing, there was some debate whether Mrs A was partly or fully unable to make decisions with regard to her care and finances. The judge's final decision was that Mrs A "wholly lack[ed] the capacity to make decisions relating to her day to day care and specifically her physical and medical needs".[3]

Following the appointment of Mrs A's welfare guardian and property managers, arrangements were made for her to return to her apartment with 24-hour nursing care in place.

Appointment of the nursing agency

The first task for the new property managers and welfare guardian was to find the nursing agency to provide care to Mrs A. Mr H, one of Mrs A's property managers, advised me that the public hospital had recommended the nursing agency.

Mr B was the director of the nursing agency, a company that has since gone into liquidation and was struck off the register of companies effective from May 2004. Mr B acted largely in a managerial role for the company, but was also a registered nurse and at times also acted in that role. He advised me that the nursing agency provided full-time nursing, attendant/personal care, and domestic assistance in Mrs A's apartment from the time of her discharge from hospital until her death. Initially, the nursing agency provided only nursing and attendant/personal care services, with some domestic assistance, but later also assumed responsibility for further domestic matters, including shopping and "running the apartment". Mr B agrees he was the central figure in the care of Mrs A but advised that there were a number of other key players.

Mr B described key members of the team involved in Mrs A's care as including general practitioner Dr F as well as the nursing agency staff members including Ms C, onsite team

[3] PPPR Case, reserved judgment, Auckland, August 2000.

leader and registered nurse, Ms E, operations manager and registered nurse, and himself, as the nursing agency director and registered nurse. He further advised that "the day-to-day care of [Mrs A] … was the responsibility of nursing agency staff who were overseen by myself, [Ms E] (until her resignation from the nursing agency), [Mr J] (Welfare Guardian) and [Mr I] (Property Manager)".

Mr I was the property manager based in the city and he shared the role of property manager with Mr H, who was based in an overseas country. Mr H clarified that Mr I did not have any responsibility for Mrs A's day-to-day care in his role of property manager. Mr I's role was to manage Mrs A's financial affairs and he did not play a part in decisions related to her care and welfare.

Ms E advised me that Mr B's role was to be "the primary nurse in planning and crucial rostering", to communicate with all the relevant parties regarding Mrs A's care, and to purchase the equipment to support her needs. It was Mr B's decision for the nursing agency to take on the care of Mrs A.

Other necessary discharge arrangements – occupational therapy
The public hospital initially made arrangements for an occupational therapist to assess Mrs A's home in May 2000. The referral form, completed by the Occupational Therapist, states in part:

> "Pt [patient] to return home to be cared for by 2x full time caregivers including x1 registered nurse, this is at present on a trial basis only."

The occupational therapist's visit did not occur until August, because of the other arrangements that needed to be put in place. Mr B met with the public hospital community occupational therapist at Mrs A's home, to determine what equipment would be needed to provide adequate nursing and personal care. A note from the occupational therapist in Mrs A's public hospital records, dated 10 August 2000, states that the necessary equipment for Mrs A was not yet in place. The equipment that Mrs A would require at home was listed, including a Roho cushion and a pressure care mattress.

The note further states:

> "[Mr B] reiterated that he would organise all of the equipment and did not want any assistance to set it up. He stated that he would contact the community OT if needed. …"

Mr B advised me:

> "After the OT's consultation and recommendations the following equipment was arranged for [Mrs A's] home:
>
> - hospital bed and sectional mattress, with over-bed table
> - ripple mattress
> - walking frame

- wheelchair
- anti-decubitus cushion (for chair and wheelchair)
- commode
- multiple pillows for positioning (in bed and seated)."

In response to my provisional opinion, Mr H provided a copy of an invoice dated 10 August 2000 for equipment for Mrs A, which had been forwarded to him from the nursing agency. This confirms purchase of ten items of equipment, including a wheelchair, a special bed, a cushion and pillows. The invoice described the cushion purchased as a "Max cushion" and also listed a "three section mattress" and a "pressure relief mattress overlay".

Discharge information
Dr O's detailed discharge letter of 13 August 2000 summarised Mrs A's medical and behavioural problems, and provided relevant information about her social situation. The letter was copied to the nursing agency and Dr F.

In addition, a nursing discharge letter was provided to the nursing agency by the public hospital ward:

> "To: [the Nursing Agency]
>
> Thank you for accepting [Mrs A] into your care, she has been a patient here since 17 March 2000 and is being discharged 14 August 2000.
>
> Nursing assessment: Continence presents a problem as [Mrs A] is frequently incontinent and wears a nappy – during day and night. (Urine and occasional faeces – regular toileting may help.) …
>
> Behaviour: Demanding and requires firm kind limits – at other times [Mrs A] can be pleasantly directable. She often shouts abuse and has a history of physically abusing nurses eg – kicking, hitting, pinching.
>
> Night behaviour: Reluctant to retire at night, however while in hospital [Mrs A] goes to bed at 8.30pm. She requires full assistance with her ADLs [activities of daily living] and creams to her sacrum.
>
> Other relevant information: [Mrs A] is a high risk for falls and requires two nurses to transfer. She has the use of a high gutter frame and is able to weight bear with this. At times [Mrs A] will tolerate short walks [with] staff.
>
> Add: [Mrs A] has a small blister on her lower central back that will need monitoring."

Discharge on 14 August 2000 – staffing arrangements
[Mrs A] was finally discharged to the care of the nursing agency on 14 August 2000.

Once Mrs A was at home, her care was provided by a team of nurses and caregivers working in shifts rostered by Mr B. According to the staff timesheets, the caregiving staff

worked in rosters alongside nursing staff members. Mr B advised me there were initially two staff members on duty at all times.

The following staff members were notified of my investigation:

Mr B
Mr B was a registered nurse with dual roles – both as a manager with primary responsibility for the provision of Mrs A's care and as a "hands on carer" from approximately August 2001. He was also the director of the nursing agency contracted by the property manager to provide in-home care services to Mrs A.

Mr B described his role with the company in relation to Mrs A as "overseeing" her care. In his management role he was responsible for ensuring an appropriate overall standard of care. This included the responsibility to put in place adequate and appropriate numbers and skill mix of staff caring for Mrs A. He also had a responsibility to ensure adequate staff training took place, appropriate rostering decisions were made, and that appropriate referrals were made to support front-line staff.

As the manager of Mrs A's care, and a registered nurse, Mr B was responsible for ensuring that appropriate care planning decisions were made and documented, and that appropriate equipment was purchased. He also had a responsibility to accurately report Mrs A's condition to other key caregivers, including her general practitioner, in order to seek their support and co-operation in providing an appropriate level of care.

In his role as a registered nurse, he was additionally responsible for providing appropriate treatment to Mrs A when her pressure areas started to develop by initiating appropriate further assessment and review, and ensuring that her pain was appropriately managed.

There is no evidence that Mr B had any initial hands-on involvement in Mrs A's care. The staff rosters show he was present on Mrs A's arrival home from the public hospital, but otherwise his presence is not noted in the staffing rosters or daily progress notes until Mrs A's final months in the care of the nursing agency. It is therefore unclear how Mr B's nursing role changed as staffing reductions started to occur. In response to my provisional opinion, Mr H informed me that Mr I had told him that Mr B was to visit Mrs A twice weekly from June 2001. The frequency of Mr B's visits is unable to be confirmed from the nursing documentation. It is noted that Mr B's first entry in Mrs A's progress notes was on 17 August 2001.

In terms of prevention of pressure areas, Mr B advised that he supplied equipment for Mrs A, that she was showered daily, and he instituted physiotherapy exercises. The physiotherapy referral appears to have occurred on 17 August 2001, the date of Mr B's first entry in Mrs A's progress notes.

On this date, Mr B recorded Mrs A's blood pressure, arranged a physiotherapy referral and followed up concerns recorded by a caregiver the previous day. The caregiver had noted that Mrs A had had no treatment on her hands since her nails had been "cut to the quick" six days previously, and that no first aid kit had been supplied as requested. Mr B recorded in

response that he had supplied a first aid kit and had inspected Mrs A's thumb and index finger, which were "Quite OK". The next record by Mr B is dated 22 August 2001, noting a visit by the locum GP. His next record, on 10 September 2001, notes that he visited to inspect Mrs A's pressure sore and to change the dressing, and further notes "Please report any changes directly to [Ms N] or myself". (Ms N was one of the caregivers involved in Mrs A's care.) From this point on, Mr B made notes in Mrs A's records approximately every two days, documenting his changing of Mrs A's dressings.

Mr B advised me that he was not aware of Mrs A's foot ulcers. I have been unable to determine when Mrs A's foot ulcers started to develop, because of a lack of documentation.

Mr B submitted that Mrs A was a difficult patient to treat, and that he was one of a team involved in her care. However, he also acknowledged that the nursing care of Mrs A was "the responsibility of [the nursing agency] staff overseen by myself, [Mrs E] (until her resignation), and [the welfare guardian and property manager]". Mr H disputes that the property manager had any responsibility for the nursing care of Mrs A.

Ms E

Registered nurse Ms E was also involved in Mrs A's care from the time of her hospital discharge, initially until April 2001. Ms E recalled attending a meeting at the public hospital with Mr B prior to Mrs A's discharge. A number of nursing staff, medical staff and legal representatives were present. Ms E advised that at this stage, she reached an agreement with Mr B that he would be the primary person involved in Mrs A's care, and she would have little or no involvement in her day-to-day care. Her role would be to provide cover alternate weekends, to be available at those times to provide advice, usually by telephone, to caregivers and Mrs A on any urgent matters, and to drop in supplies and manage relationships on alternate weekends. Ms E recalled that she decided not to have Mrs A in her caseload, as care for elderly persons was not her specialty area, and she did not provide hands-on care. She was not involved in making clinical decisions related to Mrs A's care. I note that Ms E's involvement is not noted on the staff rosters (Appendices B and C) at any time.

Mr B advised me that Ms E's designation was that of "Operations Manager" and that, until her resignation in April 2001, she was one of the team who oversaw Mrs A's day-to-day care, as outlined above.

It is also noted that a single "nursing review" of Mrs A's care was documented by Ms E prior to her resignation, on 3 March 2001.

Ms E advised me that she later became involved again in Mrs A's care from approximately October 2001, after returning from overseas. She advised that she was not a "regular employee" of the nursing agency from the time she returned from overseas, and was not "Operations Manager" during that period. The records indicate occasional involvement of Ms E prior to her reinvolvement in October 2001. For example, a note by a caregiver on 11 August 2001 states that she "Called [Ms E] in …" to look at a lump on Mrs A's leg. The exact date of Ms E's reinvolvement after her resignation in April 2001 has been unable to be established.

Ms C

Ms C, a registered nurse employed by the nursing agency, was initially the senior nurse and the on-site leader of the team of nurses. As she was to be a key person in Mrs A's care, she met Mrs A in hospital the day before her discharge. Ms C advised me that in her role as senior nurse, her duties included "writing and implementing care plans, supervising caregivers and providing hands-on care".

Ms C had a lot of direct involvement with Mrs A, and appears to have established a good relationship with her. Ms C advised me that in relation to pressure area care, Mrs A would sometimes have areas of redness on her hips in the mornings, but by the time she had been showered they were gone. Mrs A was "a large lady who required two people for moving and handling". Ms C stated that she was particular about pressure care, especially because Mrs A was not keen to move herself. Ms C would check her pressure areas each day when showering her, but never saw any areas of broken skin.

Ms C advised me that Mrs A had a ripple mattress and a large sheepskin on her bed. She had a position change every two hours, either by turning in bed or transferring her between the bed and the chair. At each position change, Ms C would massage aqueous or moisturising cream on Mrs A's feet and coccyx. Mrs A had no redness on her feet at this time. Ms C would rub cream on Mrs A's bottom every two hours when she was toileted. Ms C also directed the caregivers to ensure that Mrs A was thoroughly cleaned and dried each time she was incontinent.

Ms C also advised me that, although she had been the senior nurse, in practice she had a "peer-like" relationship with other nurses and caregivers. She was not involved in matters such as staff rostering, and although she took responsibility to ensure that tasks such as picking up the groceries were carried out, she "would not have been able to tell [the other nurses] what to do".

Ms C was dismissed from the nursing agency effective from 19 January 2001. She advised me that Mrs A did not have any pressure areas or areas of broken skin during the period she was involved in her care. To the best of her knowledge, after her departure Mrs A was to be cared for by Ms D, registered nurse, and Ms G, enrolled nurse. She did not know who else was to be involved in Mrs A's care.

Ms G

Enrolled nurse Ms G also worked with Mrs A from the time of her hospital discharge. Ms G left in February 2001, and advised me that she worked on the night shift with Mrs A. This involved working from approximately 5.00pm or 7.00pm, to 7.00am the following morning, five days a week. Ms G advised that there was a bedroom next to Mrs A's for staff who were sleeping in her apartment overnight.

Ms G recalled that during the time she cared for Mrs A, she was the only caregiver on duty overnight, and that there was a double-up of caregivers, usually until 11.00pm but sometimes the afternoon caregiver would leave earlier. Two caregivers were required to assist with moving, toileting, and pressure area care and putting Mrs A to bed. Ms G's shift included awake time and sleepover. If Mrs A slept, she could sleep (in a bed in the room

next door) and although there was no bell system, if Mrs A woke she would hear her. If Mrs A woke and wanted to get up, she was told that Ms G could not move her and she would have to wait until the morning duty staff arrived.

Ms G advised that Mrs A's skin was intact when she looked after her, but pressure area care was a battle and she would rub Mrs A's bottom when she could get access to it, and when Mrs A was moving. Ms G also noted that it was not possible to move Mrs A with just one staff member, and therefore if the other staff member had to leave at 9.00pm, Mrs A needed to be put to bed at that time. Ms G could not recall a care plan and recalled verbal handovers only. She confirmed that there were no pressure areas during the time she cared for Mrs A, although she did recall some redness of Mrs A's bottom and hips, but noted that her skin was intact. She also vaguely recalled that Mrs A's toes and heels, although red, did not have any of the pressure areas or ulcers that were noted later.

Ms D

Registered nurse Ms D had initially been working with another nursing agency when she was given "a couple of shifts" caring for Mrs A. According to the staff rosters (Appendix B) these shifts occurred during Mrs A's first week at home. Ms D advised me that Ms E told her that if she joined the nursing agency she would be assured of a permanent position on "one of the three shifts".

According to the nursing staff roster, Ms D cared for Mrs A again from late December 2000 to early January 2001. She started caring for Mrs A on a more regular basis from February 2001, and her last shift was on 20 June 2001.

Ms D advised that during the time she nursed Mrs A, the only pressure sore visible was a small break in the sacral area, which was reported to Mr B as required, together with a request for dressing packs to dress the wound.

Ms D recalled that she was aware of the need for pressure area care, but had difficulty maintaining a clear regime, and providing care to Mrs A, because of Mrs A's fluctuating moods and lack of compliance.

Appointment of general practitioner

As Mrs A did not have a general practitioner in New Zealand, Dr O and Dr P made arrangements to find her one. Dr O's letter of 13 August 2000 noted:

> "If [Mrs A's] discharge to the care of [the nursing agency] does not work out she may need private hospital care or even return to [her home overseas], in which case an air ambulance may be required. If she falls acutely ill, she may need readmission to [the public hospital] for a period.
>
> [Dr P] will follow her in the community but we are also seeking a general practitioner in her locality to which [the nursing agency] and Welfare Guardian can refer to for her day-to-day medical care …"

Dr F, general practitioner, advised me:

> "I took on the care of [Mrs A] in August 2000 after a call from the geriatric registrar at [the public hospital] seeking the services of an experienced GP to care for someone who had been an extremely challenging inpatient …"

Others involved in Mrs A's care at home
There appears to have been some initial staff turnover in Mrs A's first weeks at home. A number of staff, including several registered nurses, appear to have left in Mrs A's first or second week home. A further registered nurse appears to have left in early December 2000. However, the staff turnover reduced after an initial settling period.

A letter from Dr P dated 29 August 2000, two weeks after Mrs A's discharge, noted:

> "I visited [Mrs A] for 20 minutes or so today. She is ensconced safely and reasonably contentedly back in her apartment and the two personal assistants present seem to be pleasant, capable and coping."

Mrs A's medical care was overseen by Dr F. Dr F visited Mrs A from time to time and on request, but his main involvement until September 2001 was in telephone conversations with the nursing agency staff. According to Dr F's notes, staff members would call him on a fairly regular basis, for example to discuss concerns over Mrs A's medications or to obtain repeat prescriptions.

Both Dr O and Dr P also continued to visit Mrs A after her discharge. Dr O visited Mrs A at home on 16 November 2000, 5 February 2001, 22 May 2001 and 15 November 2001. Dr P visited Mrs A on 29 August 2000 and 6 September 2000, and attended a meeting between some of the parties involved in her care on 29 November 2000.

Aside from the regular involvement of those listed above, the nursing records refer to a small number of visits by health care professionals, which appear to date from around August 2001 onwards. These included several visits from two different physiotherapists, and single visits from a podiatrist, a community nurse, and a palliative care specialist. No other professionals saw Mrs A during her time at home.

Investigation summary – pressure areas and foot ulcers
While in the care of the nursing agency, Mrs A developed several pressure areas, as well as ulcers on her feet. One of the pressure areas caused more concern than the others. When Dr O saw her on 16 November 2001, he described this area as "a huge necrotic and offensive pressure sore over the right gluteal area of which a small amount of slough has come away …"

Mrs A died later in November. Twenty post-mortem photographs of the pressure areas and ulcers on Mrs A's feet were taken by staff at the funeral home in the city. Mrs A's body was flown overseas and a further eight photographs were taken. All of the photographs were supplied to my Office, along with the following report from the embalmer.

> "[Mrs A] was transferred into my care at the mortuary of [the funeral home], at around 12.00 noon. After checking for signs of life and discussing her final disposition with her

Funeral Director […] I began to disrobe [Mrs A] and begin my pre-embalming analysis. She was wearing a nappy and had several others under her back while the left arm had white bandages stuck to her elbow and wrist and her fifth toe on her left foot had a bandaid taped around it.

Overall [Mrs A] had quite extensive ecchymosis in various locations on her body as is common to sufferers of idiopathic thrombocytopenia. It was however especially prominent on her upper left foot and heel, both forearms and in scattered locations on her right foot and both shins. Both sets of toes and maleollus bones were ulcerated and the condition of the feet in general were so poor that I decided that a separate arterial injection of this area via the anterior tibial arteries would be necessary to secure good preservation. The dressings on her left arm covered a variety of small sores most notably on the dependent portions of the elbow while the toe of the left foot under the bandaid was black with tissue damage. No dressings I encountered had any time or date written on them to indicate when they had last been changed as is common practice in many hospitals.

It was upon rolling [Mrs A] to ascertain the condition of her back that the extent of her ulceration became apparent. I had been aware of an unpleasant odour in the mortuary since [Mrs A] was brought in and assumed, due to the diaper she wore, it was purge. However upon rolling her onto her side, helped by […] (another embalmer in the mortuary) to remove the other diapers I was confronted with the source of the odour. Underneath the nappy and an adhesive dressing lay a giant expanse of decubitus ulcers. The largest was approximately eight centimetres in diameter and was situated to the right of the spine in the lower lumbar region. The tissue was obviously dead with a general black, spongy appearance and oozing putrid fluid. A red inflamed area further surrounded the patently necrotic tissue. A second ulcer which ran in a line along the top of the spinal column just above the anus having the appearance of a jagged tear was approximately five centimetres long but significantly more superficial due to the proximity of the bone. Several other ulcers were present in other locations including under the left shoulder and underneath to the left hip and a large hardened one to the underside of the right hip but none held the extensive necrosis of the first ulcer. Attempting to excise loose necrotic tissue on the same I almost immediately encountered bone and feared to incise further into the opening of the ulcer for fear of damaging the viscera of the abdomen. The general breadth and depth of the sore was 8cm x 7cm. Examining it further I noticed that the spread of the necrotic tissue went much deeper into the body than the diameter of the open wound. At this point I pointed it out to […] and also to [Mrs A's] Funeral Director […] to advise her of the delay in embalming that would ensue as a result (the entire operation ended up coming close to eight hours work, the majority of time being spent on auxiliary treatments for these ulcers); also made a point of having one of the Company Directors and a qualified embalmer, examine the wound before final treatment due to its severity. The extent of the ulcer can perhaps be gauged by the fact that hypodermic and osmotic treatment with almost 750mls of a phenol based cauterant left overnight failed to completely eliminate the odour of the necrotic tissue and re-packing and re-injection were needed. It was not until this was completed the odour was finally arrested.

> Whilst Decubitus ulcers are a common occurrence in embalming [Mrs A's] ulcers were more significant than those I and my colleagues have previously encountered in our experience as embalmers."

As part of my investigation of the circumstances surrounding the development of Mrs A's pressure areas and foot ulcers, I considered the pressure area preventive measures that were undertaken and the management of the problem once it became apparent.

In terms of preventive measures, I considered the entire period that Mrs A was in the care of the nursing agency. I examined what pressure prevention measures were documented and carried out by individual staff members, the risk factors that were taken into account, and the pressure prevention equipment used. I also considered the staffing arrangements, training, and rostering decisions that were made.

I also investigated the treatment given by the nursing agency staff and Dr F once it became apparent that pressure areas were a problem.

Before I consider the prevention and treatment of the pressure areas, I will set out the documented evidence of a developing problem with pressure areas.

Evidence of developing pressure areas and foot ulcers
There is reference to intermittent problems with Mrs A's skin, such as reddening of the sacral area, dating from prior to Mrs A's discharge from the public hospital. In particular, it is noted that Mrs A had two small broken areas on her sacrum at the time of her discharge. The nursing discharge summary from the public hospital to the nursing agency referred to a small blister on her lower central back that would need monitoring.

There are further references to areas of redness or blisters on different locations on Mrs A's body in the nursing agency progress notes. For example, on 16 August 2000, after two days at home, Dr F made a note that the two broken areas needed monitoring. A note by a registered nurse the following day states that these areas had improved, but Mrs A's buttocks and sacrum were red. A note by a registered nurse on 19 August states: "Sacrum red – Vit E applied, pressure areas drier." A further note on 10 September 2000 states: "Bottom red but not broken." The records continue in this manner, most months from August 2000 to May 2001 having at least one, or sometimes several, references to blemishes or areas of redness on Mrs A's skin.

It appears that the problems with Mrs A's skin were initially intermittent. Registered nurse Ms C did not recall a blister on Mrs A's skin at the time of her the public hospital discharge. Her recollection was that Mrs A had "lovely skin" and "nice smooth skin". A number of the other caregiving staff also had no recollection of particular problems with Mrs A's skin during her early time at home. Ms D advised me that during the period she was caring for Mrs A, "the only pressure sore visible was a very small break around her sacral area".

Mrs A's notes contain no references to ulcers on her feet. The only references to the appearance of her toes are on 3 March 2001, when Ms E completed a nursing review and

noted a bruise on Mrs A's right great toe and, in a separate note on the same day, a caregiver documented that there was some concern about Mrs A's toes after a fall.

On 11 May 2001, a progress note states: "Great day, small pressure area on bum". A caregiver observed in a further record on 18 May 2001 that Mrs A's "Bottom has small raw bedsore", and noted that she applied cream to the area. There are no care instructions documented, and there are no further notes to indicate whether the area improved.

The progress notes make no further reference to the condition of Mrs A's skin until September 2001. However, there is a reference to a problem with a pressure area in the minutes of a "[nursing agency] Review Meeting" which took place on 17 August 2001. Mr B, Mr J and Mr I were present at this meeting. The minutes state:

> "[Mrs A] has developed a pressure point at the base of her spine and this was being carefully monitored to ensure it did not develop into a problem."

The next reference to Mrs A's skin condition, documented in the progress notes, is a record by caregiver Ms L dated 7 September 2001, stating: "… Noticeable sore on her backside. Dressed with wound dressing [and] rubber tegedem …"

On 8 September 2001, Ms L noted: "… tried to nurse on side due to sore on back side". The area is not mentioned the following day, but a note by Mr B on 10 September 2001 indicates that he visited to inspect the sore and to change the dressing.

On 12 September 2001, there is a further entry from Mr B, highlighted with an asterisk and capitalised as follows:

> "PLEASE NOTE – ALL STAFF
> I have redressed the pressure area on
> [Mrs A's] sacrum. The dressing is
> securely fixed AND IS NOT TO BE REMOVED.
> I will call every second day in the
> morning to check on progress and to
> change the dressing."

From the 12 September record onwards, there are further records from Mr B in the progress notes approximately every two days, documenting his changing of Mrs A's dressings, and providing positioning instructions to staff, in order to relieve pressure.

Prevention measures

I will now consider the pressure risk preventive measures that were undertaken throughout the 15-month period that Mrs A was in the care of the nursing agency, including the nursing documentation, staff knowledge of risk factors, nutritional intake, and pressure prevention equipment used.

Documentation
Prior to Mrs A's discharge from the public hospital, a pressure risk assessment form had been completed, with an update on 11 July 2000. The assessment was based on the 'Waterlow scale' to assess pressure risk. On 11 July 2000, Mrs A's assessment value was 29 (a score of 20 or above indicates a "very high risk" of pressure sore development). Noted risk factors included obesity, double incontinence (urine and faeces), tissue paper skin, discoloured skin, neurological deficits and inertia.

There is no record of specific pressure area prevention documentation in the nursing agency records.

In regard to documentation, Mr B advised me:

> "Instructions to staff relating specifically to the prevention of pressure areas were given in written form in the nursing progress notes, and verbally, as was the use of specific equipment used to reduce pressure. In addition, a regularly updated care plan was always in [Mrs A's] apartment attached to the fridge. All staff were expected to view this as it also contained the daily plan for [Mrs A]."

Mrs A's records include an undated document entitled "Daily duties for caregivers", which listed daily personal care and domestic duties to be completed, such as showering Mrs A and tidying the apartment.

Although there is a document entitled "Updated Care Plan", dated 13 September 2001, there is no record of a care plan prior to this date. The 13 September document states as follows:

> "UPDATED CARE PLAN FOR [Mrs A]
>
> Points to Note
> - When lifting or transferring [Mrs A] – please use lifting belt or the hoist.
> - Encourage [Mrs A] to exercise arms and legs 3-4 times per day.
> - Dressing on sacrum is to be examined only and not changed without reference to [Mr B].
> - On Monday morning please check the supply of [Mrs A's] medication for the next seven days. Notify [Mr B] when supplies are running low and document in the nursing notes that you have ordered more.
> - When you first come on duty, ensure that you read the nursing notes from the previous 24 hrs so that you are aware of any new issues or matters you need to be aware of.
>
> Daily Duties for all Caregivers
>
> Mornings
> - Shower as necessary (at least every two days), and wash hair
> - Settle in recliner chair with tissues, drinks and telephone at hand
> - Prepare and serve breakfast

- Do any laundry, and hang out to dry
- Make bed and tidy apartment, vacuum as necessary
- Check grocery supplies. Fax major weekly shopping list to office. Purchase minor items as necessary using petty cash. Keep all receipts.
- Prepare and serve lunch and snacks as necessary
- Spend time chatting or sitting quietly with [Mrs A]

Afternoon
- Fold and put away laundry
- Prepare and serve evening meal
- Clean kitchen including floor as necessary
- Spend time chatting or sitting quietly with [Mrs A]
- Prepare [Mrs A] for bed
- On your way home please take down all rubbish

Evening / nights
- Ensure [Mrs A] [is] settled in bed with drink and tissues within reach. Refill hot bottle as necessary
- Sit with [Mrs A] if she is wakeful or unsettled
- Leave the TV on low volume
- Tidy lounge
- Tidy spare room before you go home."

The remainder of the nursing agency records consist of daily progress notes, medication charts, and staff timesheets. After Mrs A's first month or two at home, the amount of detail recorded in the progress notes started to reduce. From the onset of the year 2001, there is a single nursing review by Ms E on 3 March 2001. The remainder of the progress notes refer primarily to what food was prepared for Mrs A that day, and sometimes refer to her behaviour or mood, or note a blemish or an area of redness on her skin.

Staff knowledge of risk factors

There are no documented references to pressure area preventive measures undertaken, apart from an occasional reference in the progress notes to Mrs A being turned. It was therefore necessary to obtain further information from caregiving staff in order to determine their knowledge of pressure prevention measures.

This information could not be obtained from Mr B or Ms D, because neither responded to requests for additional information.

However, Ms D provided the following information in her letter of response to the complaint:

> "As an RN I am very aware and mindful that a person who spends a lot of time on her bed is vulnerable to getting pressure sores. In fact, if a person does develop a pressure sore it is considered bad nursing practice. In saying this to avoid the inevitable one had

> to be turned every two hours and in [Mrs A's] case this was not possible due to her fluctuating moods."

Ms D had documented this problem in a nursing progress note dated 17 August 2000. This note states "… Repositioned her but she does not settle unless she is facing the window. It is not possible to turn her two hourly as she refuses to settle on any side other than her left."

Ms C advised me that it was obvious that Mrs A could potentially develop pressure areas because "she never moved. And we all know that if you don't move you get pressure areas." Ms C managed this problem by making Mrs A get up to go to the toilet, and by moving her around. She also advised:

> "I always massaged her bottom, not because she had pressure areas, but because you always do that with everybody."

Ms C noted that Mrs A was often reluctant to retire at night, and that if she had been allowed to stay in her chair overnight she would be at further risk. Sometimes there would be an area of redness when Ms C first got Mrs A up in the morning, but there were no pressure areas in the time she was caring for her.

Ms E advised me that she was not involved in Mrs A's day-to-day care, although she would sometimes sit with Mrs A and massage her feet. She was not responsible for making notes in Mrs A's records, and did not regularly read the notes. Ms E could not recall seeing any measures of Mrs A's nutrition or fluid intake in the nursing notes.

However, Ms E was aware that Mrs A had a number of risk factors. She advised that Mrs A's skin integrity was at risk because of her reduced mobility, and also recalled that she had a platelet disorder. Mrs A was at further risk because she was sometimes incontinent, and she was reluctant about her nutrition. Ms E stated that these were all significant risk factors for developing problems with skin integrity or pressure areas.

Ms G also advised me that she was aware of Mrs A's risk of pressure areas. Ms G had worked on the night shift with Mrs A, and stated that when she was assisting other staff to settle Mrs A at night she:

> "… always made sure to clean [Mrs A] properly, after [the] toilet to prevent skin irritation, [to] change her pad when needed and [provide] frequent pressure area care. This was done by always giving [Mrs A] a thorough bed sponge. … Particular attention was given to her back, buttocks, hips and feet that were always rubbed down well with cream and pillows arranged under them as to relieve pressure. In the night, she is turned and pad checked whether it needed to be changed or not …"

Ms G recalled that Mrs A sometimes had areas of redness, which could be an early sign of a pressure area developing. When this happened Ms G would rub the area to relieve the pressure, and move Mrs A. A couple of times Ms G put a transparent dressing on Mrs A for extra reinforcement, although Mrs A's skin was intact while she was caring for her.

Ms G said that she felt Mrs A's weight was stable during the time that she cared for her, although there were no scales available in Mrs A's apartment to weigh her. Mrs A was a fussy eater and difficult to cater for. Ms G advised that when Mrs A refused the food that was prepared for her, nothing could be done.

Ms K was one of the caregivers who cared for Mrs A during her last months at home. Ms K said she would sometimes see red marks when she showered Mrs A, which could indicate that a pressure area was developing. However, it was not her role to do anything about it, and she would leave it for someone else to attend to. She could contact Mr B for advice if she needed it, and did so when she had concerns, for example she talked to him about what to buy Mrs A when she was concerned about her refusing to eat. However, Ms K advised me that she did not feel well supported by Mr B.

Nutrition
Although there are no recorded measures of Mrs A's weight, there is evidence to suggest that her weight dropped dramatically during her time at home. While at the public hospital, Mrs A had been described as obese in her hospital records.

Mrs C, who cared for Mrs A during her early time at home, described her as "a large lady who needed two people for moving and handling".

However, a number of people who saw her in her last months of life referred to a dramatic weight loss. Mrs E advised that Mrs A had lost "a great deal of weight" in the interval between April and October 2001. Dr R, a palliative care specialist, referred to Mrs A as "extremely wasted" in his letter of 18 November 2001.

The nursing agency daily progress notes frequently recorded what food was prepared for Mrs A during the shift; however, there is no formal record of her intake.

I also note that a caregiver had expressed concern about Mrs A's diet soon after her discharge. On 16 August 2000, Ms M made a note observing that although Mrs A appeared to be settling down, "[my] main concern was the fact she didn't appear to have adequate food to maintain a balanced diet".

Pressure prevention equipment
Mrs A's equipment was not reassessed by an occupational therapist after the initial home visit that occurred prior to her hospital discharge. The equipment that was used was not clearly documented in the nursing agency records, although Mr H was able to provide a copy of an early invoice for equipment purchased. Overall, it has been difficult to ascertain

what equipment was in place because of the vague recollections of the staff involved in Mrs A's care. For example, Mr B did not specify whether the "specialised" cushion he purchased was a Roho cushion, and other staff members could no longer recall. The invoice supplied by Mr H does not specify a Roho cushion. The "updated care plan" refers to a hoist being used, but it is unclear how long this had been in place. Neither Ms G nor Ms E could recall a hoist when they were first caring for Mrs A, but Ms E thought she could recall one being present in October 2001.

Ms G also recalled the use of a ring device, and the use of this device is also noted by Mr B on 25 September 2001, when he documented "Hospital bed ring supplied to relieve pressure to lower back/buttocks. To be used whilst in bed or on chair …"

According to Mr B and Ms C, Mrs A also had a "ripple mattress" on her bed. Mr B advised that this was eventually replaced by a Roho mattress on the recommendation of Dr O. This occurred five days prior to Mrs A's death, according to Mr B's progress note stating: "Roho mattress to be set up by [Mrs E] tomorrow."

Staffing arrangements

After Mrs A's initial period at home, reductions in the skill level and number of the nursing agency staff caring for her started to occur. I have investigated these changes and their impact on the services that were provided to Mrs A. I have also considered the staff training that occurred and the rostering decisions that were made.

There is conflicting information about the reasons for the staffing reductions, and their exact dates are unclear owing to lack of documentation. However, the following information has been ascertained.

Mr B advised me that although Mrs A's initial care had been provided solely by registered and enrolled nurses:

> "After several months, the staffing situation was reviewed, and after consultation with [Mr J] and [Mr I] [one of the property managers, now deceased] the staffing ratios were altered to have a registered nurse on duty 24 hours a day supported by a caregiver. This change was also run past [Dr O]."

Mr B advised me of two further staffing reductions. He provided the following account:

> "A further staffing review was conducted and on [Mrs A's] overall health stabilising, in conjunction with [Mr J] and [Mr I], it was decided to staff [Mrs A's] home with two caregivers on duty at a time and eventually this was reduced to a caregiver on at all time[s] supported by a second caregiver in the mornings and afternoons/evenings. A registered nurse was always available by phone and normally visited 4 to 5 times per week to monitor [Mrs A's] condition."

Mr H advised me that although Mr I had informed him that there was to be a "slight" reduction in costs after March 2001, Mr I had no involvement in decisions related to Mrs A's welfare.

There is no documentation in the nursing agency records to indicate the dates that the changes occurred, the rationale for the decisions, or who was consulted. There is also no evidence to substantiate the incremental nature of the changes that were described by Mr B. However, it is clear that by the time the reductions were complete, Mrs A was frequently in the care of a single caregiver for lengthy periods of time.

It appears that an early staff reduction coincided with the removal of registered nurse Ms C from the nursing agency staff roster. Ms C's last day was 19 January 2001.

The removal of Ms C is referred to in a diary entry of "[the nursing agency] Review Meeting" dated 21 December 2000, made by Mr J, the welfare guardian. Although the minutes of this meeting were not included with the nursing agency records, Mr J had started keeping a diary record of his regular visits to Mrs A from 28 November 2000. Mr J made the following account of the 21 December meeting in his diary:

> "We had [the nursing agency] review meeting today at 21.30. As [Mr H] was in town he was able to attend. [Mr B] took the minutes this time. We advised [Mr I] and [Mr H] of our resolution to take [Ms C] off [Mrs A's] roster early in the new year. This will happen as part of our ongoing process to reduce the cost of [Mrs A's] care. The caregiver team to be supervised by a RN [Registered Nurse] and initially the RN will visit each day. If this seems successful the frequency of the RN visits will be reviewed …"

Mr H also recalled a "short" meeting, which according to him took place on 22 December 2000. The purpose of this meeting was to discuss the removal of Ms C from the staff roster and her replacement. Neither Mrs A's general practitioner and her geriatricians, nor any of the caregiving staff appear to have been present at this meeting. Mr H denied that the removal of Ms C was confirmed to himself or to Mr I at this meeting. Mr H also advised that there was no discussion about cost cutting by anyone at the meeting.

Staffing changes – recollections of caregiving staff

Various staff involved in Mrs A's care recalled a meeting to inform them of staffing reductions, and/or recalled the reductions occurring. The meeting to inform the staff appears to have been a separate one from the December meeting. However, none of the staff was able to recall relevant dates.

Some of the caregiving staff expressed their concerns about the adequacy of the staffing arrangements to my investigation staff. The recollections of staff are as follows.

- Ms C confirmed that she was told to go, and that the reason given to her was that it was a cost-cutting measure. Prior to her removal, there had been a meeting with Mr B and the registered staff, who were told that they were going to have to cut staff down, but that Ms C "would be going first".

  Ms C advised me of her understanding that after her removal, Mrs A was to be cared for by registered nurse Ms D and enrolled nurse Ms G.

  The nursing staff rosters do not show any replacement for Ms C, and show no registered nursing staff involvement in Mrs A's care for the first month after Ms C's departure. From February 2001, Ms D started working a rostered shift approximately once or twice weekly. According to the staff rosters, Ms D was the only registered nurse involved in Mrs A's care during the period from February 2001 until Ms D's departure in June 2001.

- Ms D also recalled the meeting where the registered staff were informed of pending staff reductions. She advised me that Mr B informed the registered nurses that he had been advised by either the property manager or the welfare guardian (Ms D could not remember who) that they would have their hours reduced. According to Ms D, the meeting was informed that the decision was made because of budgetary constraints. There was no letter following the meeting to authenticate this information.

  Ms D advised me that she believed the care that Mrs A deserved would be compromised, as Mrs A was not easy to care for and, in Ms D's view, she should have had "two people caring for her all the time". However, she did not voice her concern about this to Mr B. Ms D advised me:

  > "I was concerned at this stage as [Mrs A's] care was going to be the prime responsibility of the caregivers and [Mr B]. I think it is unfair to expect the caregivers to carry this responsibility. My other concern was the absence of the Property Managers or Guardian Welfare at this meeting to confirm this information as correct but we accepted this information without further ado. After all we are only employees!"

- Ms G, the enrolled nurse, also recalled a meeting where the staff were informed of cutbacks. Ms G did not express an opinion at this meeting as to whether the proposed level of staff was appropriate because "it's not for me to say". Privately, she said she "knew … what's going to happen to [Mrs A]", that her level of care was going to drop.

- Ms K, who worked the 3.00pm to 11.00pm shift from December 2000 until Mrs A's death, recalled that when she first started caring for Mrs A, Ms C would be on the shift with her. Later there were two caregivers. Both would start duty together, then one would finish her shift, leaving one caregiver on duty. A second caregiver would return to "finish" at the end of the day.

  Ms D left in June 2001. Ms K advised me that there was no replacement registered nurse once Ms D left, and this is confirmed by the staffing rosters. If Ms K needed advice, she could seek it from Mr B, who had started coming in once or twice a week to change Mrs A's dressings.

  The nursing agency progress notes record four visits by registered nurses during the period from June 2001 until the documentation of pressure sores in September 2001. These visits consisted of one by Ms E on 11 August 2001, who visited to look at a lump on Mrs A's leg, and three by Mr B later in the same month.

  Mr B's instruction to Ms K at the time of his regular visits to change Mrs A's dressings was to turn her on her side every two hours, which Ms K would try to do. She could not recall any other instructions from Mr B.

Other impacts of the staffing reduction
It took two caregivers to mobilise Mrs A, or to assist with her toileting. When the staffing level reduced to a single caregiver assisted by another caregiver in the mornings and evenings, Mrs A was unable to be safely lifted or toileted during the times when only one staff member was on duty.

Ms D advised me:

> "It generally took two people to wash or shower [Mrs A] safely or even to change her position in bed but staff were often left alone with her. Sometimes she would accidentally soil herself and staff would have to wait until another staff member arrived before anything could be done … For me this was a safety issue and a concern for both staff and client."

Mr J, Mrs A's welfare guardian, recorded Mrs A's views about the restrictions caused by limited staffing in his diary entry of a visit to her on 8 February 2001:

> "[Mrs A] is still grumpy today. She cannot explain what is wrong or why she is so unhappy. Staff report that she is being quite un-cooperative and difficult. I explained the need for her to maintain a routine to ensure that staff can manage as some tasks need two people and must be done during the shift overlap. Clearly she is not convinced and would prefer greater flexibility."

Several days later, another entry by Mr J reported that Mrs A was "feel[ing] out of control and very frustrated".

Ms G also advised of her problems toileting Mrs A when she was on night duty by herself. This was dealt with by placing a napkin on Mrs A. Ms G could move Mrs A around enough to change her napkin if necessary; however, she was unable to assist if Mrs A wanted to get up. Sometimes Mrs A would ask Ms G to help her to the toilet during the night, and she would have to be told it was not possible. On these occasions, Ms G would "just continue to say to [Mrs A] that she could not get her up".

Mr J recorded another incident when the toileting restrictions upset Mrs A on 20 March 2001:

> "Visited late afternoon and [Mrs A] was quite upset. She was certain she had soiled herself and was quite impatient for the evening shift to arrive so she could be changed. I helped [Ms M] to move [Mrs A] to the commode so she could have a movement. Her pad was clean and dry so she was upset over nothing."

The staffing level also meant that Mrs A was unable to decide what time she would like to go to bed, although she had always liked to retire late at night. It was sometimes necessary for her to retire by 9.00pm, so the second caregiver would still be available to assist with settling her. According to Ms G, when they attempted to put Mrs A to bed at this time she would say: "No, no, no, I've got a programme coming on. I want to see the programme", and she would want to go to bed at 11.00pm. It was not always possible for the second

caregiver to wait until 11.00 to finish her shift, but Ms G said that sometimes Mrs A would "fight" to such an extent that the second staff member would wait.

Staff training and rostering decisions
There is no documentation of the staff training that occurred. Mr B advised me that all caregivers were trained in correct lifting and transfer techniques.

The staff rostering decisions were also made by Mr B. These decisions had an impact on the care provided to Mrs A both because of the number of hours some staff were rostered to work, and because of a problem in the caregiving relationship between Mrs A and one of her carers.

There is evidence that some of the staff were rostered to work long hours dating from not long after Mrs A's discharge. There are many examples of staff working in excess of 10-hour shifts from the beginning of Mrs A's time at home (see hours highlighted in orange in Appendices B and C). Some of the weekly hours worked were also excessive – for example, Ms C worked 70 hours in the week 28 August to 3 September 2000. There is evidence of particular caregivers working long hours on a regular basis, and these hours increased over time. The staff rosters show that from approximately April 2001 onwards, two of the caregivers, Ms K and Ms T, frequently worked in excess of 60 hours per week. There is increasing reference to staff working double shifts (16 hours) from approximately April 2001. Ms T, in particular, often worked close to, or in excess of, 100 hours a week during Mrs A's last months. During October 2001, some caregivers worked 24-hour shifts, with the relief of another caregiver only for several hours in the morning and/or evening.

Another problem was apparent in the caregiving relationship between Mrs A and one of the caregivers, Ms L, Mr B's daughter. Ms C and Ms K both mentioned this problem during interviews with my investigation staff. Ms C advised that when Mrs A was aggressive, Ms L would respond by "screaming back". Ms C would tell Ms L that there was no point in doing that as it would just antagonise Mrs A more.

There are also frequent references to Mrs A's problem with Ms L in Mr J's regular diary notes. For example, on 4 January 2001 Mr J noted: "[Mrs A] is unhappy with [Ms L] and wants her removed from the roster." In response, Mr J told Mrs A he would speak to Mr B about it, and later noted that he had done so. On 8 January 2001, Mr B advised Mr J that he would be visiting Mrs A to discuss the situation with her. However, it is unclear whether the visit eventuated and, if it did, what the discussion entailed.

On 5 February 2001 Mr J noted that Mrs A "would wait for the next shift to arrive rather than have [Ms L] attend to her". There are other frequent references to Mrs A being "grumpy with [Ms L]" or Ms L "being in the dogbox again".

On 18 June 2001, in the context of referring to Mrs A's reluctance to bathe, Mr J noted: "I feel that she takes this out on [Ms L] more than the older caregivers but that [Ms L] is not as good at managing [Ms A]. Perhaps this is something that [Mr B] should consider." There is no further reference to a discussion with Mr B, but a note on 14 August states:

> "… [Ms L] has cut back [Mrs A's] fingernails to the point where a couple of them are so short that they have been bleeding. This is the second time [Ms L] has cut her nails really short and they were only just growing back to a more normal length.
>
> I discussed this with [Ms M, another caregiver] when she relieved [Ms K] and we agreed she should call [Mr B] to discuss this. We are both concerned that this action seems a little extreme as none of the other staff have reported being scratched by [Mrs A]. "

Mr J advised me that he had a telephone conversation with Mr B about reducing the number of shifts that Ms L was doing and "introducing some new faces" at some point in mid-2001. He recalled that Mr B was finding it difficult to find suitable staff. Mr J further advised me:

> "The relationship between [Ms L] and [Mrs A] seemed to improve over time and I had no further cause for concern."

There is an entry in Mr J's records on 14 September 2001 stating "[Ms L] seemed to be coping better than some recent visits", and after this the regular references to Mrs A's complaints about Ms L ceased. However, it is also noted that by this time Mrs A's general condition was starting to deteriorate and she was less responsive in general.

Ms L remained on the staff roster until Mrs A's death.

Treatment

Dr F advised me that he first became aware of Mrs A's bedsores when Mr B requested he visit on 20 September 2001. Dr F advised me that on this visit:

> "… I found her to be febrile and septicemic, probably as a consequence of cellulitis secondary to bedsores and a possible chest infection. The previous visit on 22 August 2001 was made by my locum […] and he made no reference to bedsores in his note. I would normally expect the nursing staff to notify me if they were concerned about bedsores being an issue. When I saw her on 20/9/01 I was concerned enough to discuss the case at length with the surgical registrar at [the public hospital]. This included advice regarding wound management with the option of admission being considered but given her dementing illness, access to 24 hour nursing care and reluctance to enter hospital it was decided to treat her at home. Advice was given to [Mr B] regarding her care and her septicaemia responded well to antibiotics but subsequent phonecalls and a visit confirmed little improvement in her bedsores despite appropriate wound care. I had detailed discussions with [Mr B] on wound management on a number of occasions. Her lack of improvement was in part due to difficulties in protecting pressure points in a poorly compliant patient. [Mrs A] also suffered from idiopathic thrombocytopenic purpura and anaemia on which I consulted with her haematologist [Dr Q] and which complicated her wound care. She was however comfortable and receiving excellent nursing care and given the overall deterioration in her cognitive function I believe the right decision [to keep her at home] was made. On 2/11/01 a call from [the nursing agency] indicated that [Mrs A] was febrile and my locum at the time […] elected to prescribe a course of antibiotics. Ultimately I sought the further advice of [Dr O]

> (13/11/01) when her pressure sores became a significant nursing issue and it was at this stage that a decision to engage in palliative care was made. "

On 21 September 2001, the day after he first became aware of Mrs A's pressure sores, Mr B advised Dr F that her condition had improved, and that he would provide daily wound care and liaise with Dr F regarding her progress.

Mr B advised me that he had sought advice from a "wound care specialist" about the appropriate treatment for Mrs A's wound. He documented his intention to make this referral on 1 October 2001, when he recorded that the "area of erosion" had increased, and he intended to check with an "Ebos wound specialist" as to the best material to use for the dressing.

However, it is unclear when the visit Mr B was referring to took place. There is no documentation of a visit by a wound specialist in the nursing agency notes. In relation to this visit, Mr B advised me:

> "I sought the advice on more than one occasion from a nursing wound care specialist [Ms S] who attended [Mrs A] at my request to examine and comment on the nursing treatment being used) …"

Ms S confirmed that she was contacted by Mr B, and recalled visiting Mrs A on one occasion. Ms S advised that at that time her job title was "community nurse". She is not a wound specialist and although she had received standard nursing training, she had no special training in dealing with wounds such as Mrs A's.

Ms S advised that she had had business contact with Mr B before, and on this occasion her role was to "support [Mr B] and check his product usage". Her visit was not to evaluate the care/treatment being offered to Mrs A. The nursing wound specialist decided that the product was appropriate; she advised my investigation staff that she did not need specialist wound care knowledge to make this decision. According to Ms S, Mrs A did not require specialist wound care.

Although Ms S felt that the product being used was appropriate, she said it would not do anything to heal the sores that she saw. The sores were necrotic, and the only treatment that would have been effective, in Ms S's view, was surgical debridement. Although Ms S's recollection is no longer clear, she thought that debridement had been considered, but was not pursued because of Mrs A's debilitated state.

Ms E's return

Ms E also became involved in Mrs A's care again in October 2001. According to the nursing agency records, this involvement was for the four-day period from Thursday 4 October to Sunday 7 October 2001. Ms E recalled that her only other involvement was when she was asked to attend a single meeting at Mrs A's apartment on an occasion when Mr B was unavailable approximately two weeks later. However, the nursing agency records refer to Ms E's involvement on several occasions from October 2001. She also appears to have been involved in Mrs A's palliative care.

Ms E advised me that when she saw Mrs A in October:

> "[She] was in bed when I attended her and two of [the nursing agency] staff were also present. I dressed two large pressure areas on her sacrum and hip. The pressure sores had formed large cavities, had copious exudate and were malodorous. I do not recall doing any other dressings."

Ms E described the difference in Mrs A's condition between April and October 2001. In October:

> "… She was not very responsive. She was sleeping and lethargic. Which was a major change. She responded to verbal stimulation and would open her eyes, ... but she wasn't conversing voluntarily … She had lost a great deal of weight or had appeared to. You know people look small when they are sort of shrunken and in bed and of course the pressure sores. Which, that was quite surprising to me … I was expecting to go and dress pressure sores but I hadn't quite anticipated that they were so severe."

However, at the end of her four-day period caring for Mrs A, Ms E recorded in the progress notes:

> "[Mrs A's] pressure areas are slowly improving. Well done to you all for your excellent efforts in keeping [Mrs A] off these areas. It's making a huge difference. …"

Wound dressings and pain management

Ms E said that the dressings for Mrs A's wound were there when she arrived. According to Ms E, these dressings were "designed to deal with a lot of exudate", but nevertheless were "pretty sodden by the end of 24 hours". Ms E felt the dressing was appropriate, but was concerned "about ongoing management of pain, exudate and odour". She discussed these concerns with Mr B on the Monday morning of his return. Ms E advised: "While the product [Mr B] was using would seem to me to be suitable … I recall I asked him if he had a review because that would seem to me to be prudent."

With regard to the management of Mrs A's pain, Ms E advised me that she was unsure whether Mrs A was in pain. Ms E advised:

> "… [I]t was something that was in my mind, but she certainly didn't give any verbal or physical clues. She wasn't really very responsive. … it would be hard not to have some pain associated. I don't know at that stage whether there was … she didn't express [it] to me."

Ms E explained that she did assess Mrs A's pain, and was unable to find any verbal or physical indications of pain. Ms E did not document her pain assessment.

The medication records indicate that for the majority of her time at home, Mrs A was given one Paradex and/or a Panadol tablet approximately daily. This level of medication increased from 20 September 2001, when Mrs A was given regular paracetamol liquid in addition to a daily Paradex tablet. The pain medication started to decrease again from approximately 26

September 2001, so that by 2 October Mrs A was usually having just one Paradex tablet daily. On 5, 6, 12, 13 and 20 October, no pain medication was given.

Continuing treatment – Dr F
Dr F's records show telephone contacts with the nursing agency between 21 September and 15 October 2001 regarding requests for repeat prescriptions. On 15 October 2001 Dr F telephoned Mr B, who reported that Mrs A's wounds were "healing satisfactorily" and there were "no major nursing problems".

On 25 October, Dr F visited Mrs A and viewed the pressure areas again. Dr F's record on this date notes:

> "… pressure ulcers still requiring treatment – no real improvement …"

He also noted an overall deterioration in Mrs A's condition on this date.

On 30 October 2001 it is noted in Dr F's records that he discussed Mrs A's anaemia with Mrs A's hospital haematologist, Dr Q. The possibility of a transfusion was discussed but decided against.

On 2 November 2001, Dr F's locum recorded a telephone call from the nursing agency noting that Mrs A had an increased temperature and required antibiotics. Dr F telephoned the nursing agency on 12 November, and arranged to visit Mrs A the following day, as Mr B was concerned that her pressure areas were not healing.

On 13 November Dr F visited Mrs A and viewed her pressure areas again. His records of this date state: "very concerning 7 x 5cm decubitus ulcer [right] sacroiliac area …". On this occasion he telephoned Dr O to arrange a review.

Palliative care
Dr O reviewed Mrs A at home on 14 November 2001. He recommended a Roho mattress for Mrs A, and arrangements were made to set this up the following day.

Dr O also made arrangements for Mrs A to be seen by palliative care specialist Dr R in her home on 17 November 2001. Dr R's letter of 18 November 2001 to Dr O states (in part):

> "Thank you for your referral and detailed background information. I appreciate the fact that you got consensus from all caregivers and friends re the commencement of palliative care at this stage of [Mrs A's] life. Certainly her problems are insurmountable and the palliative care approach now seems to be appropriate.
>
> I reviewed [Mrs A] in her home on Saturday the 17th of November. What I saw was much the same as you outlined in your letter. Except that she is much closer to death. From her perspective the problems seem to be:

1. Pain on movement

2. Distressing smelly bedsores

3. Cognitive dysfunction associated with antisocial behaviour

Physical examination revealed an extremely wasted lady with a pulse of 120 and a blood pressure of 70/50. Abdomen was soft and non-tender, skin is cushingoid and there are a number of superficial breakdown areas over her body. There are three large bedsores, which we will attend to with the help of [the nursing agency] staff and my specialist nurse […]. … I will review [Mrs A] frequently. Prognosis is days rather than weeks now."

Ms E recorded a brief plan for Mrs A's palliative care in the nursing notes on 17 November 2001.

There were no further nursing notes.

Geriatric reports
The following reports were requested from Dr P and Dr O, outlining their involvement in Mrs A's care, and offering their opinions on the standard of care provided to Mrs A.

Dr P's report states as follows:

"This report refers to your request dated 14 October 2003, for information on certain aspects of [Mrs A's] care. Before answering the specific questions you raise, I believe that some background information might prove useful.

Background
[Mrs A] was [born overseas but] chose to spend much of her time in New Zealand. … She had […] supported a number of charitable objects. Amongst these was [an organization and] [Mrs A] had in fact served a term as a member of the Council of that [organisation]. According to her friends, she had always had a forceful personality. By the time she was brought to the notice of Older People's Health at [the public hospital] in 2000, she was suffering from a dementing process, immobility and back and hip pain so that she was not able to care for herself. Unfortunately, her increasingly abusive behaviour had alienated friends who tried to help. Moreover, the dementia prevented her from realising the plight she was in. By way of illustration, the first time I visited her at home (16 March 2000) in response to an urgent request from a community social worker who had been contacted by a friend, she spent the first 30 minutes abusing doctors in general and me in particular. We only got through this phase when it turned out that we had mutual acquaintances on the staff of the [the organisation she had supported]. Notwithstanding this 'breakthrough' despite a further 2 hours of trying, I was unable to persuade her to accept urgent admission to [the public hospital]. This despite the fact that she was totally immobile in her chair as the result of pain, would have no-one in the house with her overnight and no way of toileting herself. She did, very reluctantly agree to admission next day.

In order to stop her from carrying out a threat to discharge herself prematurely, a personal order was taken out by the hospital under the Protection of Personal and Property Rights Act. This required her to remain in hospital until her medical attendants judged that she was ready for discharge and could arrange suitable follow-up care for her. Her lack of insight was further demonstrated by the fact that when discharged she would not accept that she needed assistance with her activities of daily living. Moving her back to a hospital in [an overseas city] was given serious consideration, but she was absolutely opposed to it. One of the considerations of a further Court Order under the P.P.P. & R. Act close to the date of her discharge home, was to prevent her dismissing her home attendants at the first opportunity.

During her admission, in addition to treating her pain and offering her rehabilitation, her dementia was investigated. A Neurobehavioral Cognitive Status Examination found that she had severe impairment of constructional ability and calculation, moderate to severe impairment of reasoning, judgement and orientation, and moderately severe impairment of memory and comprehension. Indeed the only attributes in which she scored in the reference range were level of consciousness and attention. From these results and other investigations including a CT brain scan, it appears that her dementia was due to frontal and temporal lobe damage as the result of vascular disease.

[Mrs A's] aggressive personality, judgement and insight were affected for the worse, by the dementia. There were very few people she accommodated, and even these were not infrequently the subject either in person or in absentia of screaming, abusive outbursts of a highly emotional, degrading and irrational nature. Several of the nurses could not handle her rages and visiting her in any capacity was a challenge to one's patience and self-control. A report by a Psych geriatrician, dated 18 April 2000 adds useful information to this brief background summary.

Summary of my role in [Mrs A's] care
My role for some (but not all) of the time [Mrs A] was within the ambit of [the public hospital], was that of a Community Geriatrician. That role comprised:

1. attending meetings of the community health team (comprising gerontology nurses, social workers, needs assessment and service co-ordinators, physiotherapists and occupational therapists and dietitians), to discuss the needs of their clients in the community and
2. visiting, at the request of general practitioners and, at times, members of the community team, older people with health needs living in homes, rest homes and private long stay hospitals in [the city] region, and
3. at the request of hospital medical teams, doing follow-up visits on people recently discharged from hospital. The Geriatricians of the Older People's Health team do not routinely follow up people discharged from hospital.

The last time I visited [Mrs A] at home in an official capacity was in early 2001 (my file note is missing) at [Dr O's] request to gauge her wishes about returning to [the public hospital]. (She remained adamantly opposed.) At that time her condition was stable, though my impression was that her dementia was slowly increasing.

I had also been involved in a meeting held on the 29th November 2000 in an attempt to resolve major differences of opinion between the various members of her inner circle which included:

1. [Mr J] (appointed her Welfare Guardian by the Family Court under the P.P.P. & R. Act),
2. [Mr I] and [Mr H] (her court-appointed Property Managers) and
3. [A friend of Mrs A's]

The meeting was chaired by [a lawyer]. At issue was a dispute mainly between [a friend of Mrs A's] and [Mr J's] about [a friend of Mrs A's] role in caring for [Mrs A]. [Mr J] considered that [a friend of Mrs A] was interfering with [Mrs A's] in-home nursing management (provided by [the nursing agency]) whilst [a friend of Mrs A] was angry because she felt that [Mr J] was excluding her unfairly from any role in care. ([Mr J] had limited her attendance to a maximum of two hours a day if I recall correctly.) The meeting did not end particularly amicably. A report on the outcome of the meeting was to have been prepared by the Chair for distribution to all parties, but I never received one.

Cause and treatment of the ulcers

When [Mrs A] was discharged from [the public hospital] to 24 hour nursing care in her home, written warnings about the possibility of her developing pressure ulcers were given. For example, the Support Needs Level form dated 8 August 2000 has the annotation: *'Please watch sacral breakdown. [Mrs A] is incontinent of urine and often incontinent of faeces. She wears a nappy pad at all times.'* Under the heading 'Concerns' there was added: *'Often demanding and abusive, e.g. swearing, hitting staff, kicking, pinching. Small blister on lower back. Please monitor.'*

It seems from these statements that [Mrs A] already had some minor skin damage when she left hospital. That the home-care staff did observe her is clear from the [the nursing agency] case notes which have entries every two months or so recording the state of the sacral area and buttocks. Attempts were made using appropriate dressings and positioning to protect her from further damage.

Despite these measures, the case notes indicate that pressure areas were becoming a worry by mid-September 2001. They were inspected by [Mr B] (who I understood to be a principal of [the nursing agency] with nursing qualifications) and thereafter he took responsibility for dressing the affected areas. He seems to have visited twice a week. He held a couple of discussions with [Mrs A's] general practitioner, [Dr F], and [Mrs A] subsequently was prescribed two courses of antibiotic. On September 22 the case notes state that a hospital bed had been obtained in an attempt to reduce pressure on her lower back and buttock. Unfortunately the notes do not state whether or not a pressure mattress was also obtained. (One would have been desirable.) [The nursing agency] Nursing staff might recall this detail. The nursing attendants were turning her two-hourly in bed (a weight distribution measure.) However, pressure areas continued to worsen and on September 30 [Mr B] discussed the problem with Ebos' wound specialist, particularly from the viewpoint of which dressing would be most appropriate. (Ebos

Group Ltd. is a manufacturer and importer of state of the art wound dressings.) As a result he switched to Intrasite Gel and Hydrocolloid dressings. Despite these measures, the notes through October record further deterioration in the situation. [Dr O] was consulted on November 15th. He and [Dr F] determined that a palliative care approach was the most appropriate.

Adequacy of nursing care
In my opinion, during the time I was involved with her care, her needs were being met adequately by the 24 hour nursing she enjoyed in her home. [Mrs A's] financial situation was such that she could [meet] the expense of 24 hour home nursing. She was given a hospital bed and a commode to assist with her care. As noted above, there is a question as to whether a pressure mattress was obtained for [Mrs A's] bed.

Transfer to private hospital
In my opinion, [Mrs A] would not have tolerated a move into a private hospital even had one been contemplated. It would have required further involvement with the Family Court and a new Court Order. [Mrs A] had a morbid fear of hospitals of any kind. She was convinced that they were full of infection. She had a fear that she would die in hospital and frequently expressed her concern (including to me) about being compelled to go to hospital.

It is in any case not at all certain that transferring [Mrs A] to a private hospital would have arrested the progress of the decubitus ulcers given that she had 24 hour care at home.

Predisposing factors contributing to the development of ulcers
A number of predisposing factors might have played a role in the development of ulcers. She was an obese woman who had a painful back and hip and who would sit for hours in the same place and resist efforts to move her. She had been treated with steroids for an idiopathic thrombocytopenia for several years and as a result her skin would have been vulnerable. She was a long time smoker, and it may well be that her peripheral vasculature was compromised. She was also incontinent much of the time so that her hips and buttocks would have been damp even if wearing continence pads.

Referral to wound care specialist and dietitian
I can only give a general opinion about this, not having any first hand knowledge of the sequence of events in [Mrs A's] case. However, I would expect that caregivers who experience problems with decubitus ulcers and/or foot and leg ulcers would call for assistance and advice from an ulcer nurse specialist or the Ulcer Clinic at [another public hospital]. However, this would depend upon the level of expertise the care-giving team itself had. [Mr B] may have had such expertise. Obviously, the earlier in the development of an ulcer help is sought, the better. As for dietary consultation, that can be useful in certain circumstances e.g. where a person is unable to eat regular meals, or despite doing so is losing weight. When the problem is that a person refuses to eat well, dietary advice might be less useful. [Mrs A] could be remarkably choosy with her food. If she objected to what was provided she would not hesitate to throw it around the

room. However, I do not have specific information about [Mrs A's] appetite or attitude to food in the last months of her life.

Cause of weight loss
I cannot comment, not having been a party to her care in the latter part of 2001. In that she was somewhat obese when I first met her, some weight loss would have been appropriate. According to the medication records, her steroid therapy was withdrawn on 30 October 2001. That might have contributed to weight loss over the subsequent weeks.

Referral for surgical review
Surgical management of severe decubitus ulcers can be useful in some circumstances. One has to make a judgement, especially in the case of elderly dementing people whether subjecting them to an invasive surgical procedure such as flap transfer is appropriate. Surgical intervention is always a resort of last choice when other more conservative measures have failed to produce healing."

Dr O's report states:

"Summary of my role in [Mrs A's] care. I was the consultant physician caring for [Mrs A] throughout her [public hospital] admission 17/3/00 to 13/8/00 and this is described in my discharge summary of 13/8/00. I subsequently visited her at home on 16/11/00, 5/2/01, 22/5/01 and finally on 15/11/01 at which time I recommended palliative care ….

The medical features of this admission were a two year history of decreasing mental state and mobility on a background of osteoarthritis of the right hip, primary thrombocytopenic purpura [low platelets and bleeding tendency] on corticosteroids since 1996, cataract operations, treated thyrotoxicosis, smoking and small multiple strokes. With the help of observation, psychiatry and neurological consultants and X-rays including head CT scan we made a diagnosis of vascular dementia (CT scan showed multiple small strokes) with frontal lobe symptoms and immobility due to a combination of steroid myopathy, arthritis and impaired balance (fear of falling) from her dementia. The admission was punctuated by a life threatening septicaemia requiring a Court Order to force treatment.

[Mrs A] proved to be one of the most challenging patients I have ever cared for because of her psychosocial problems. The dementia seemed to have released the full force of her previously reported strong minded and controlling personality. She was intensely abusive, often yelling, spitting, throwing food and other objects. Decision making was complicated by her history of living partly [overseas] and [partly] in her [city] apartment, sometimes conflicting opinions of friends and advisers in both places, the risk of air travel and some uncertainty about exactly where [Mrs A] herself wanted to be.

Initially I applied for a Court Order to retain her in hospital (she was demanding to leave despite inability to walk) and return her under sedation to [her home overseas]. However she made it repeatedly clear she wished to return to her [city] apartment and a

large meeting of all parties agreed to this. A further Court Order was required to ensure the essential 24 hour nursing care could be funded and not sent away.

Throughout my care of [Mrs A] I was assisted by my colleague, [Dr P] who was involved with organising her original admission to hospital and also helped me with follow up home visits.

2. Pressure sores and ulcers.

a) Cause? The primary cause was prolonged unrelieved pressure over bony points. Because of the predisposing factors (see below #5), [Mrs A] was at high risk of pressure sores and 'prolonged' could have been anything over two hours or even less.

b) Prevention. Even in the best hospitals pressure sores can occur but rarely if ever to the extent seen at my visit to [Mrs A] on 15/11/01. She had small pressure sores while in [the public hospital] probably similar to those documented at home around March 01. The severe pressure sores seen later in [Mrs A] were preventable by a combination of skilled nursing, regular turning when in bed, use of a Roho cushion or similar on her chair, and a special mattress e.g. Roho or ripple in which alternate strips of mattress are inflated and deflated by a pump. An indwelling urinary catheter may have been helpful to keep her skin dry but at the expense of infected urine.

c) Treatment options were to continue preventive measures noted above, remove dead tissue in the ulcer (if minor this debriding could have been done with dressings and if more severe surgical debridement by a surgeon in a hospital theatre would be required), antibiotics only if there was infection with surrounding skin, referral for help to a wound care specialist or myself.

d) Were these options pursued? Amongst other equipment, a Roho cushion and pressure care mattress were mentioned in the occupational therapist pre discharge home visit report of 10/8/00 following the words '[Mr B] to organise'. I do not know whether these items were procured and must admit that I did not check on them at my subsequent visits. The local dressings used on [Mrs A's] ulcers (2/10/01) in [the nursing agency] notes were similar to what we would use in a public hospital. I note instructions to keep her on her side 'when possible ... especially at night' on 3/3/01 with the first mention of two hourly toileting on 20/9/01. This turning is not mentioned in nursing instructions of 13/9/01 or earlier (undated). I am not sure from reading [the nursing agency] notes whether a special mattress or cushion was used. It should be noted that [Mrs A's] dementia and behaviour may have made intensive turning difficult. Finally [Mrs A] was not referred back to myself during the time when her ulcers were worsening. I regret that I did not continue my regular visits between my last visit of May and my final visit in November. I would note that [Mrs A's] personality and behaviour made it difficult to achieve ideal care even in the public hospital environment.

3. Staffing mix and equipment. There is insufficient information to comment on staff mix and numbers. My belief was that [Mrs A] had sufficient funds for whatever staff

mix/numbers were required. I would have expected a registered nurse to have been employed for at least a part of every day. Equipment would have been a hospital bed and a special mattress as above. The only equipment mentioned is a bed ring which we now generally consider obsolete as they may exacerbate pressure sores. My impression reading through all of the [the nursing agency] notes was that the nursing notes were rather social and I felt could have been more structured with daily notes reflecting the formal nursing plans and a temperature pulse and respiration chart at least once daily.

4. Private hospital. [Mrs A] was very clear about wishing to remain in her own home and this should have been achievable given her potential to pay for full 'hospital at home' care until her death. When her pressure sores worsened in September 2001, specialist advice was required and the outcome may have been more intensive care at home, or temporary public hospital admission, or private hospital care. I am pleased she managed to live out her life at home but her last weeks should not have included the severity of pressure sores I saw on 15/11/01.

5. Predisposing factors to ulcers were:-

(a) Complication of her low platelet disease i.e. steroids which cause skin atrophy and camouflage infection, bruising compromising skin integrity and anaemia (I am not sure when her last haemoglobin was measured but a blood transfusion may well have been indicated at some point).
(b) Her behaviour made it difficult to get her to lie or sit in a particular position.
(c) Incontinence makes soggy skin. An indwelling catheter may have helped. There is not a record of this.
(d) Immobility.
(e) Under-nutrition.

Her [the public hospital] notes included a Waterlow score [pressure risk assessment] and this was 29 at the time of discharge. It would have been similar at home. Very high risk is >20.

6. Wound care specialist nurse/dietitian. From the time of admission to [the public hospital] in March 2000 to her death [Mrs A] required hospital level care and was at risk of malnutrition, skin breakdown, worsening mobility – hence intermittent review by dietitian, physiotherapy, specialist ulcer nurse were justified throughout this time. This attention certainly occurred in [the public hospital] but broke down on discharge home. The referrals to these specialist carers should probably have been made at the time of discharge from [the public hospital]. Looking back, her continuing behavioural problems may have also justified follow up by a psychiatrist or a community psychiatric nurse.

7. Weight loss. [Mrs A] was overweight in 1996 and on admission to [the public hospital] in March 2000. Her weight of 80 kilograms at that time fell to 76 kilograms by May 2000. There was no record after that. I suspect she was never underweight but nevertheless was severely malnourished with loss of muscle mass (sarcopenia). This has a number of causes including reluctance to eat (she was reported even in 1996 to not

like 'New Zealand food' and [the nursing agency] notes do indicate reluctance to eat), inactivity and muscle wasting from steroids.

8. Surgical review. Although pressure sores can be managed medically, we usually involve surgeons at least for help with debridement (removing dead tissue) and sometimes skin grafting. I may have readmitted [Mrs A] to [the public hospital] and involved surgical colleagues if I had seen her earlier i.e. around late September/early October 2001 when it seemed the pressure sores were definitely worsening. The exact timing of this worsening is not certain from the nursing notes.

9. Deterioration and death. [Mrs A] died of sepsis (probably pneumonia and septicaemia from the necrotic pressure sores) but this needs to be seen in the context of multiple strokes, advancing dementia (with associated behaviour on psychological symptoms of dementia – BPSD), chronic platelet disease on Prednisone which masks infection, malnutrition and a bed/chair fast immobility. These latter factors were the cause of her progressive deterioration."

Palliative care specialist's report

The following report was provided by palliative care specialist Dr R:

"Regarding your queries about the above patient of mine. I am sorry for the long delay in replying but there are many mitigating factors. In answer to your questions:

Pressure sores develop due to prolonged lying in one position. Usually this is a result of profound disability, paralysis or lack of sensation in the affected area. The other contributing factor in some cases is cognitive dysfunction. In [Mrs A's] case there are a number of factors contributing to this distressing condition. I would list them in order of priority as

1. Profound dementia
2. Steroid induced loss of skin integrity
3. Immobility due to steroid myopathy, and back pain
4. Idiopathic thrombocytopenia purpura ITP.

Prevention of the development of this situation was undertaken by the services of the [public hospital] Specialists, particularly [Dr O]. This was unsuccessful mainly because of [Mrs A's] personality and dementia. [Mrs A] refused to follow good medical advice. This combination of factors was to prove lethal. The hospital notes testify to many years of not following medical advice, being abusive and being cognitively impaired.

I felt on review that everything that could have been done was being done with the exception perhaps of committal to a psychiatric hospital on the grounds of self-neglect and then enforcing care. I do not think voluntarily she would have accepted any more care than was provided. This was her undoing, not poor care on behalf of the professional staff. Hence treatment options were offered and vigorously turned down by the patient.

The factors that led to [Mrs A's] death were consequent upon the profound disability that she suffered from and again this was due to both cognitive dysfunction and disease.

She became more and more frail and more and more immobile, therefore prone to infection. Steroids as a treatment for her ITP probably did not help but they are a recognised treatment option at this phase of life. Their use was thoroughly discussed and weighed up. More extensive nursing care, high tech mattresses and moving beds would have been of help. But there is no doubt in my mind that [Mrs A] would have refused this and she would have needed to be committed under the Mental Health Act.

Her eventual death would have been caused by a further episode of sepsis either from the pressure sores or the urinary tract. When I saw her she was in fact close to death and I enclose my clinical letter at that time. Certainly I agreed with the medical opinion that further intervention was not warranted due to the terminal nature of her condition.

Please let me know if I can help further."

Independent advice to Commissioner

General practitioner advice
The following expert advice was obtained from Dr Tessa Turnbull, an independent general practitioner:

"**REPORT TO THE HEALTH AND DISABILITY COMMISSIONER**

COMPLAINT FILE 02/08905/am

'To provide independent advice about whether [Mrs A] received an appropriate standard of care from GP [Dr F].'

In compiling this report, I have viewed the following documents:
- Complaint by [Mr H] (PM)
- Notification of complaint to [Dr F]
- Additional information supplied by [Mr H], including embalmer's report and photographs
- Response to complaint from [Mr B], director of [the nursing agency]
- Response from [Dr F]
- Medical records from [Dr F]
- Letter 4/11/02 with note from [Dr F]
- Copies of [the nursing agency] and [the public hospital] files
- Diary notes supplied by Welfare Guardian [Mr J]

Background

[Mrs A] was discharged from [the public hospital] to her home on 13/8/00.

Her nearly 5 month admission on 17/3/00 was precipitated by a visit to her apartment from [Dr P] of [the public hospital] at the request of her friend [Mr J]. [Dr P] found her immobile and incontinent at home and she very reluctantly agreed to be admitted to [the public hospital].

Her ongoing medical problems at discharge were firstly idiopathic thrombocytopaenia (a low platelet count for unknown reasons). High dose steroids had been used without benefit in the past and she was discharged on lower dose dexamethasone and azathioprine.

[Mrs A's] mobility was severely limited by osteoarthritis of the right hip and the spine, also peripheral neuropathy with a left dropped foot. Her immobility was also related to steroid myopathy (muscle wasting) and a fear of falling i.e. it was considered to be multifactorial in origin.

There was also dementia of a frontal lobe type as determined by the history and testing and supported by CT scanning. This type of dementia often produces a personality change and [Mrs A] was described as having an abusive personality as evidenced by the nursing notes from [the public hospital].

[Mrs A] also had background medical problems of obstructive lung disease from smoking, thyrotoxicosis (an overactive thyroid), cataract operations, urinary problems and previous gall bladder surgery.

During her prolonged admission she had had pneumonia and septicaemia requiring a PPPR personal order for treatment.

[Dr O], a physician in Geriatric Medicine at [the public hospital] notes in his discharge summary that [Mrs A] had deteriorated mentally over the past two years at least. During her hospital admission she had been extraordinarily demanding and often abusive.

[Mrs A] had no close relatives. She had lived both in New Zealand and overseas.

Prior to her discharge she had refused to allow 24-hour care which was required to keep her safely in her own home. She clearly wished, however, to be in her own apartment in [a city].

In a meeting with her friends and hospital staff it was decided to apply to the court for a Welfare Guardian and a Property Manager to be appointed.

The court appointed [Mr J] as Welfare Guardian.

His task was to make decisions on behalf of [Mrs A] who the court determined was unable to do this herself i.e. [Mrs A] 'wholly lacked the capacity to make or communicate decisions' (1)

Two Property Managers, [Mr I] and [Mr H], were also appointed by the court.

These appointments can be made for people who 'wholly or partly lack the competence to manage his or her own affairs in relation to his or her property'. (1)

[Dr F] was asked to take over the continuing care of [Mrs A] at home. [Dr F] is a Fellow of the RNZCGP and has a central [city] practice.

He visited [Mrs A] regularly and on request and was in regular contact with [the nursing agency] staff. He acted as an overseer and manager of her medical problems.

[Dr P] continued to oversee the medical care. He visited her on 29/8/00 and 11/9/00. [Dr O] continued to visit monthly for several months i.e. until May 2001 and he reported that all was well generally and that he was happy with [Mrs A's] management and ongoing care.

[Mrs A's] day to day care was the responsibility of the [the nursing agency] and its staff. 2 full time trained/enrolled nurses initially supplied this care with input from a family friend. After several months, this changed to one registered nurse and one caregiver full time. Later this was 2 caregivers at all times with regular visits from a registered nurse 4-5 times a week to monitor [Mrs A's] condition.

[Dr F] became aware of the pressure sores first on a visit on 20/9/01. [Mrs A] was running a fever and [Dr F] wondered about a chest infection and possible septicaemia from an infection in the pressure sores. He discussed the case with the surgical registrar at [the public hospital] including the option of a hospital admission or wound care at home.

As in the past, it was agreed that it would be [Mrs A's] wish to be at home and generally in her best interests for the medical and nursing care to be provided there.

[Mrs A] seemed to improve generally with antibiotics but the pressure sores remained an ongoing problem. Further antibiotics were prescribed by [Dr F's] locum in early November but despite this the pressure sores became worse. Therefore, [Dr O] was asked by [Dr F] to see [Mrs A] again which he did on 15/11/01.

He reported 'quite severe' sacral and gluteal pressure sores, probable pneumonia, anaemia and her ongoing chronic medical problems.

He said the sacral sore was healing well except for some slough but there was a huge necrotic and offensive pressure sore over the right gluteal area. Also an impending pressure over the right great trochanter and left upper chest. There were no pressure sores on her heels.

It was agreed that palliative care would be started at home rather than debridement of her ulcers in hospital.

[Dr R] provided this from 18/11/01 and a specialist palliative care nurse supplied nursing input.

[Mrs A] died at home [in November 2001].

'To advise the Commissioner whether the services provided by [Dr F] to [Mrs A] were of an appropriate standard'.

- *What level of responsibility did [Dr F] have for preventing pressure sores from occurring?*

[Dr F] had overall management of [Mrs A's] medical problems. These were complicated and progressive.

The development of pressure sores occurs as a result of the interaction of many health factors. In [Mrs A's] case these were:

1. Immobility

[Mrs A] was confined to a chair/wheelchair and bed because of her problems of arthritis, myopathy, and neuropathy.

2. Nutrition

This was a continuing problem as detailed in both the nursing notes, [the public hospital] notes and those recorded by her Welfare Guardian, [Mr J].

3. Incontinence

Urinary incontinence was an ongoing problem and fecal incontinence a later problem. Daily showering was provided although vigorously opposed by [Mrs A].

4. Dementia

This was clearly progressive and meant that [Mrs A] was unable to cooperate in changing positions regularly, understanding the nutrition issues and so on.

5. Anaemia

This occurred as a result of the ITP. Low dose steroids were required to treat this and caused/compounded the problem of myopathy.

[Mrs A's] care, including medical, social, mental and nursing aspects was a partnership between [Dr F], [Mr J] and the nursing/carers from [the nursing agency]. It had input from [Dr P], [Dr O] and [Dr Q] of [the public hospital] and later [Dr R] and his specialist nurse. Specialist equipment was supplied by [the public hospital] and included a hospital bed, ripple mattress, wheelchair and later a Roho mattress as suggested by [Dr O].

[Dr F] worked with the above, and all had a role in the prevention of pressure sores. No pressure sores were apparent until September 01 after which they became an ongoing and serious issue.

- *Comment on the appropriateness of [Dr F's] actions once the pressure sores were brought to his attention?*

This seems entirely appropriate ie. antibiotics, liaison with [the nursing agency] staff and consultation with surgical staff at [the public hospital].

- *Was the care plan for managing the pressure sores appropriate?*

Yes, I believe entirely appropriate.

- *Should [Dr F] have referred [Mrs A] back to the hospital for further review by the geriatricians or more intensive management of the pressure areas?*

Liaison with [the public hospital] staff was ongoing from the time of [Mrs A's] discharge in August 2000. There was a gap in [Dr O's] visits between May and November 01. However, [Dr O] was happy with [Mrs A's] care during his regular visits and [Dr F] knew that he was able to contact him should he have felt the need, as he did in November 01.

The role of the Welfare Guardian is impressive. He visited regularly and appeared to understand and respect [Mrs A's] wishes, knowing her well before she became sick.

He was involved in the decision to manage [Mrs A's] terminal illness at home i.e. from her rapid deterioration from September 01.

- *Should an assessment have been arranged to establish whether [Mrs A] required hospital level care? If so, whose responsibility is it to arrange this?*

[Dr F] did this in discussion with the surgical registrar on 20/9/01. He had sufficient ongoing contact with [Mrs A] to understand that she wished to remain in her own home and could afford to have the appropriate care provided there.

It was at this point [Mrs A's] care became 'terminal' i.e. the medical problems compounded and [Mrs A] did not have the capacity or the desire to resist them any longer.

- *Are there any other matters relating to professional or ethical standards which are relevant to this complaint?*

Providing good quality professional care to people in their last year/s of life is very often a challenge. [Mrs A] typifies this to an extreme degree.

It seems to me that all those involved in [Mrs A's] care supported her, respected her wishes and managed her medical and nursing and emotional needs in a professional and ethical way.

(1) The Protection of Personal and Property Rights Act 1988."

Further general practitioner advice
An additional report was requested from my general practitioner advisor, Dr Tessa Turnbull, requesting further comments about Dr F's response to the provisional facts of this case, and the report of Ms Jenny Eastgate. Dr Turnbull's comments on the additional information that had been obtained since her first report were also requested. Dr Turnbull supplied the following additional report:

"To further advise the Commissioner whether [Dr F] provided appropriate care to [Mrs A].

Additional Information
A. Jenny Eastgate's report 21/8/03
B. [Dr P's] report 12/11/03
C. [Dr O's] report 24/11/03
D. Letter [enclosing [Dr F's] response] 7/10/04
E. The Commissioners provisional report

1. Does any of the new information alter your previous opinion that [Dr F] provided services to [Mrs A] with reasonable care and skill?

No. As previously mentioned [Dr F's] role was an advocate and medical advisor to [Mrs A] during the time between her discharge from [the public hospital] on 13/8/00 and her death [in November 2001]. [Mrs A's] management in the wide context of clinical, nursing, emotional and social factors, was a team effort between her GP, her court appointed Welfare Guardian and her nursing providers with specialist input from [Dr O], [Dr P], [Dr Q], [Dr R] and others. Good communication and networking is essential in such a situation.

There were some serious deficiencies in the flow of information to [Dr F] from the nursing provider especially in the last few weeks of [Mrs A's] life.

I believe that [Dr F] provided services to [Mrs A] with reasonable care and skill as evidenced by:
A. Clinical notes and letters to the Commissioner show understanding of the case and its multiple complexities
B. Faxed medication changes to the nursing provider were clear
C. Directions were given to [a home help service] to provide physiotherapy services on 5/11/01.
D. Communication with other specialists was proactive ie with [Dr Q] when [Dr F] noted the falling Hb which became critical on 13/6/01. Changes were made to her medical management at this time. [Dr F] also consulted the

surgical registrar at [the public hospital] when he visited [Mrs A] at home on 20/9/01. The decision was made to be proactive with wound management and antibiotics. A follow up call to [Mr B] the following day indicated some improvement in her general state. A further phone call to [Mr B] on 15/10/01 was reassuring to [Dr F] as the information back indicated 'satisfactory wound healing and no major nursing problems'.

E. [Dr F] and his locum continued oversight of the pressure sores between this time and 15/11/01 by which time they had become significantly worse and [Dr F] requested a further visit from [Dr O].

F. It seems clear from the worsening clinical situation and the falling blood counts, that [Mrs A] entered a terminal or palliative phase in early November 01. Referral back to [Dr O] could have been made a week or so earlier so that appropriate palliative cares measures could be instituted. However, this is looking retrospectively and [Dr F] believed that a high standard 24 hour nursing care was being provided with registered nursing input.

G. [Mrs A] made it very clear that she wished to remain in her own apartment and not be transferred to a hospital, and it is clear that her medical advisors understood and respected this wish. Moreover, she could clearly afford to do this and there should have been no constraints to offering her the best possible care at home.

2. Review [Mrs A's] blood test results and [Dr F's] comments. Was it necessary for [Dr F] to take any action in response to the test results such as seeking nutritional advice? If so, when?

   [Mrs A] had complex medical problems, and a specific blood disorder ie Idiopathic Thrombocytopenic Purpura (ITP). Her blood tests were monitored regularly by [Dr F] with specialist input as required from [Dr Q].

   [Mrs A's] Haemoglobin (Hb) at discharge from [the public hospital] on 13/8/00 was 133 with a normal film and a ferritin of 113.

   The Hb fell slowly from that time until 12th June 01 when it reached 94 and a pancytopaenia with increased macrocytes was noted. The platelets remained very low the whole monitoring time.

   Because of the fall in Hb [Dr F] consulted [Dr Q] at [the public hospital] on 13/6/01. The drug azothiaprine was thought to be the culprit so it was decided to stop this, increase her steroids, do some further blood tests, and in particular to check the B12 and Folate levels to exclude a deficiency in these areas. The B12 level was fractionally low but a repeat test on 7/8/01 showed this level to be comfortably normal.

   The change in treatment was initially positive with the Hb bouncing back to 104 on 7/8/01. There were subsequent readings of 96 on 5/9/01 and 63 on 29/10/01. As indicated earlier [Mrs A] reached the terminal phase of her life in early November 01. [Dr O] mentioned a blood transfusion may have been appropriate

but the only indication for this, would have been 29/10/01 based on the blood count. Clinically this would not have been appropriate at this stage.

Nutritional advice would not be sought on the basis of these blood tests but on her clinical state. Nutritional supplements are often disliked by patients and it is highly likely that [Mrs A] would have refused to drink them given her history of food likes and dislikes and her dementia.

3. Was it necessary for [Dr F] to arrange, or be involved in, any comprehensive initial assessment of [Mrs A] when she was first discharged from hospital?

   No, [Dr F] had very comprehensive information about [Mrs A] from [the public hospital] discharge summary and had personal contact with the discharging doctor.

4. Does any aspect of the additional information warrant further comment?

   No…"

Nursing advice
The following expert advice was obtained from Ms Jenny Eastgate, an independent nurse consultant:

"**Medical/Professional Expert Advice – 02/08905/AM**

Professional Advice provided by Ms Jenny Eastgate RGON, Nurse Consultant, Aged Care.

In my opinion, [Mrs A] suffered a severe and prolonged period of abuse and neglect from the people appointed to care for her welfare. Age Concern New Zealand Incorporated define Elder Abuse and Neglect as the following:

Elder Abuse *occurs when a person aged 65 or more experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another person with whom they have a relationship implying trust.*

Elder Neglect *occurs when a person aged 65 or more experiences harmful physical, psychological, material/social effects as a result of another person failing to perform behaviours which are a reasonable obligation of their relationship to the older person and are warranted by the older person's unmet needs.*

It is clear from the embalmer's report and the graphic photos that [Mrs A] suffered immensely from the abuse and neglect shown to her. I believe the primary people responsible for this abuse and neglect are: [Mr B], Director and Registered Nurse of [the nursing agency] and [Mr J], Welfare Guardian; [Mrs A] was entrusted into their care, they failed to discharge their duties to her. It is my belief that [Mrs A] did not receive appropriate, professional and humane care from [Mr B] and that he is in breach of the Nursing Council's Code of Conduct for Nurses and Midwives 1995 and of The Code of

Health and Disability Services Consumers' Rights. I believe that [Mr J] did not deliver appropriate and humane care to [Mrs A] expected from a welfare guardian and that he is in breach of the Family Court Order.

1. *Please explain how pressure sores and foot ulcers develop.*

Pressure areas and foot ulcers develop through continual pressure on the area. The Textbook of Medical-Surgical Nursing by Brunner, Emerson, Ferguson and Suddarth describes the '***Preventing and Treating Decubiti.***

The prevention of decubitus ulcers (bedsore) is one of the most important considerations in the nursing care of patients. It is a complication that in most instances is due to poor nursing care. Such a sore is due to pressure that produces ischemia and consequently impaired nutrition to the tissues. This deprivation causes the cutaneous tissues to be broken or destroyed, and there is a progressive destruction of underlying soft tissue. The ulcer may be extremely painful and very slow to heal. Bacterial invasion and secondary infection are difficult to avoid. The lesion, if large enough, permits a continuous loss of serum, which may deplete the circulating blood and the entire body of essential protein constituents.

Any patient who is stuporous, emaciated, incontinent, paralyzed, or whose treatment involves the immobilization of any portion of the body is in constant danger of developing a decubitus ulcer'.

An article about the 'Vicair Academy Mattress in the prevention of pressure damage' by Fiona Collins (British Journal of Nursing, 2002, Vol 11, No 10) states '*Intrinsic factors are the internal elements which lower the body's response mechanisms, i.e. reduce the skin's ability to cope with the extrinsic factors of pressure shear and friction, thus predisposing the person to pressure ulcer development (Clarke, 1997). Intrinsic factors include: increased age; incontinence; malnutrition; neurological deficit; and reduced mobility'.*

2. *Please explain methods for preventing the pressure areas and foot ulcers from developing.*

Methods which may be used for the prevention of pressure areas and foot ulcers include: pressure reducing mattresses and chair cushions; regular 2 hourly turning by 2 staff members; use of turning *devices* to aid turning and prevent friction such as 'Slippery Sam' turning sheets; avoidance of rubbing bony prominences; avoidance of 'doughnut-type devices' (e.g. hospital ring device); correct incontinence aids; a well balanced nutritional intake and maintenance of ideal body weight.

3. *Were there any predisposing factors that contributed to [Mrs A's] development of the pressure areas and foot ulcers? If so, please explain.*

[Mrs A] had several predisposing factors that would have contributed to the development of pressures areas and foot ulcers. [Mrs A] had been assessed by [the

public hospital] Nursing Staff on their pressure risk assessment chart as being 'very high risk', with risk factors including; '*obese, doubly incontinent (urine and faeces), tissue paper skin, discoloured skin, neurological deficits and inert (mobility*)'. On admission, [Mrs A] had pressure areas specified as the elbows (see nursing assessment) and in fact developed several small broken sacral pressure areas during her stay in [the public hospital] (see progress notes; 1/5/00, 29/7/00 (reddened sacrum), 1/8/00, 6/8/00); reddened heels (7/8/00); broken blisters on back (12/8/00, 9/8/00); broken area inner thigh (12/8/00). [Mrs A] has previously had an ischaemic ulcer; this is discussed in a letter, dated 28/11/96, by [a haematology registrar]. The letter states '*evidence of peripheral vascular disease with an ischaemic ulcer over the medial aspect of the left big toe*'.

[Mrs A] also had a hematology condition, Chronic Idiopathic Thrombocytopenia Purpura, which resulted in her being prone to skin bruising from bleeding caused by destruction of platelets (refer to [Dr Q] letter 10/3/97 for diagnosis). [Dr Q] states in a letter, dated 17/4/98, under diagnosis '*Diabetes mellitus – refuses any intervention*'; he discusses in a previous letter, dated 15/4/98, '*Unfortunately she has developed glucose intolerance on the Prednisone*', this is also a predisposing factor. Review by the Neurology Registrar at [he public hospital] (28/7/00) notes '*Background of 1 Probable fronto-temporal dementia', 'long term steroids', '1 Immobility – proximal myopathy secondary to steroids, disuse atrophy, OA (osteoarthritis) R) hip, overweight. 2 Peripheral neuropathy – sensory – feet - + L) foot drop'*, these are all predisposing factors that could contribute to pressure area development.

4. Were the measures taken to prevent pressure areas and foot ulcers from occurring appropriate and adequate in the circumstances?

In my opinion, the measures that were taken to prevent pressure areas and foot ulcers from occurring were not appropriate or adequate in the circumstances. [Mrs A] had been assessed by [the public hospital] Occupational Therapist as requiring a '*pressure care mattress*' on discharge into the care of the nursing agency. The Occupational Therapist's Community Health Services Referral Form also states '*Patient to return home to be cared for by 2 x full time caregivers including x1 registered nurse, this is at present on a trial basis only*'. In [the public hospital] progress notes, 10/8/00, the Occupational Therapist states '*[Mr B] re-iterated that he would organize all of the equipment and did not want any assistance to set it up. He stated that he would contact the community OT if needed… P/ [Mr B] ([the nursing agency]) to organize the following; …1 x roho cushion, …1 x pressure care mattress*'. At that stage, [Mrs A] was still able to weight bear using a gutter frame and with the assistance of 2 staff members, and was able to '*tolerate short walks with staff*' (Nursing transfer letter to The nursing agency, 14/08/00). [Mrs A's] Support Needs Assessment Report, dated 8/8/00, states '*Please watch Sacral Breakdown. [Mrs A] is incontinent of urine and often incontinent of faeces*'. [Mr B] states in his letter to the Health and Disability Commissioner, 2/12/02, '*the following equipment was arranged for [Mrs A's] home …. Ripple mattress …. Anti-decubitus cushion (for chair & wheelchair). 5. [Mrs A] was turned in bed, or repositioned in her chair at least every two hours. 6. A further*

staffing review was conducted and on [Mrs A's] overall health stabilizing, in conjunction with [Mr J] and [Mr I], it was decided to staff [Mrs A's] home with 2 caregivers on duty at a time, and eventually this was reduced to a caregiver on at all time supported by a second caregiver in the mornings and afternoons/evenings. 11. The ripple mattress initially used by [Mrs A] was replaced with a Roho mattress, on the recommendation of [Dr O]. 13. [Mrs A] spent virtually the entire period from discharge to her death either sitting in a chair (on a specialized cushion) or in her bed (hospital bed with ripple or Roho mattress)'. The [the nursing agency] nursing progress notes state *'Large bowel motion at 23.30. Managed to change and clean [Mrs A] but left the bottom sheet soiled. Sorry but pad in place to keep [Mrs A] off it (1/2/01); Important to sit [Mrs A] on padded seat to reduce pressure and skin friction (17/9/01); Hospital bed ring* (doughnut-type device) *supplied to relieve pressure to lower back/buttocks to be used whilst in bed or on chair (25/9/01); Roho mattress to be set up by [Ms E] tomorrow' (14/11/01*, [Dr O's] letter is dated 15/11/01 but states he visited [Mrs A] on 16/11/01). In my opinion, there is serious doubt that [Mr B] did indeed obtain a Roho cushion, which is a type of '*Anti-decubitus cushion*' for [Mrs A's] use when sitting up in a chair or wheelchair, a padded seat does not describe a Roho cushion.

In relation to [Mrs A's] nutritional status, she was described as *obese* (17/3/00) and *overweight* (28/7/00) in [the public hospital] notes. I note that [Dr R], the palliative specialist, stated in his letter, dated 18/11/01, to [Dr O] '*Physical examination revealed an extremely wasted lady*', clearly [Mrs A] must have had significant weight loss since her discharge from [the public hospital]. There is a note written by a [Ms M], caregiver, dated 16/8/00, stating '*My main concern was the fact she didn't appear to have adequate food to maintain a balanced diet*'. There is documented evidence in the [nursing agency] progress notes that [Mrs A] did not appear to be receiving adequate nutrition, many entries indicate combinations of 'soup, custard, stewed apple, icecream' (9/4/01, 10/4/01, 12/4/01, 13/4/01, 14/4/01, etc). There are comments about lack of supplies available, 3/4/01, '*no toilet paper, no tea bags, no milk, no paradex. I rang the office…..message left on answer machine about lack of food*'. There is no evidence that [Mrs A] or her diet was ever assessed or reviewed by a dietitian. There is no evidence of any assessment or reassessment or weighs by a Registered Nurse, or that [Ms M's] concerns regarding [Mrs A's] diet was followed up. If [Mrs A] had resided in a private hospital, she would have received a diet based on a Dietitian approved menu, plus had an assessment by a Dietitian and received nutritional supplements and/or special dietary foods as the Dietitian assessed her as requiring to meet her nutritional needs, particularly to meet the increased need for protein when pressure areas are evident. Linda Russell wrote 'The importance of patients' nutritional status in wound healing' (British Journal of Nursing, 2001, (Supplement) Vol 10, No 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*'. Linda Russell (Tissue Viability Nurse Specialist, Queen's Hospital, Burtons Hospitals, NHS Trust, Belvedere

Road, Burton on Trent, England) also wrote the article 'Malnutrition and pressure ulcers: nutritional assessment tools' (British Journal of Nursing, 200, Vol 9, No 4). She states '*Implications of poor nutritional intake – Poor wound healing and increased wound dehiscence, Acceleration of the development of pressure sores, More susceptibility to infections, Muscular atrophy, Increased level of toxicity of drugs*'. She also goes on to say '*Prolonged protein/energy malnutrition and deterioration in immunity and weight loss is connected with increased morbidity and mortality (Chandra and Joshi, 1982*)'.

In view of the fact that [Mrs A] had several predisposing factors, there are many entries in the [the nursing agency] progress notes, dating from as early as 17/8/00, in relation to reddened areas, broken areas, blisters and pressure areas, I believe the pressure care equipment which has been documented was inappropriate and unsuitable for [Mrs A]. I did not find any evidence that [Mrs A] had ongoing referrals to Occupational Therapists as stated by [Mr B] in his letter to the Health and Disability Commissioner. I did not find any evidence that [Mrs A's] dietary needs were assessed or reviewed by a Dietitian, which should have occurred as part of pressure area prevention.

5. Was [Mrs A's] nursing care plan appropriate in the circumstances?

In my opinion, [Mrs A's] nursing care plan was inadequate and inappropriate. [Mr B] states in his letter that 'instructions to staff relating specifically to the prevention of pressure areas were given in written form in the nursing progress notes and verbally', also that a '*regularly updated care plan was always……attached to the fridge*'. I have reviewed the progress notes and found little evidence of pressure area prevention documentation, what documentation there is, is difficult to find and does not give clear, adequate and appropriate instructions. Any staff returning from leave or new staff who could have been involved in [Mrs A's] care may not have been updated verbally by the other staff and would not have known about any changes readily. There are instructions for the staff to nurse [Mrs A] on her sides (18/01/01, 12/10/01) and to turn her every 2 hours (20/09/01, 12/10/01). Instructions for the use of pressure relieving equipment, which was grossly inadequate for [Mrs A's] obvious pressure areas, were; '*Important to sit [Mrs A] on padded seat to reduce pressure and skin friction*' (17/09/01), '*Hospital bed ring* (doughnut type device) *supplied to relieve pressure to lower back/buttocks. To be used whilst in bed or in chair*' (25/09/01) and '*Must put pillow under sore hip*' (26/10/01).

The copy of the updated care plan, dated 13/09/01, does not give any pressure area prevention instructions at all. As a care plan, it is wholly inadequate and in fact is really only a series of tasks expected of the caregivers. The only nursing instructions on this care plan are; to use lifting belt or the hoist when lifting or transferring, encourage [Mrs A] to exercise arms and legs, and the caregivers were only to examine the sacral dressing and not to change it without reference to [Mr B].

For Residents in residential care, the Registered Nurses are required to complete comprehensive assessments on admission and assess the Resident for pressure area risk; and wound care, pain and continence assessments would be completed on Residents

presenting with these problems. From these assessments, a comprehensive nursing care plan is developed within 3 weeks of admission and is reviewed at regular intervals, for the current Ministry of Health Contract the review period is at a minimum of every 6 months or when clinically indicated by a change in the Resident's condition. If a Resident presented with high risk or complex needs, the care plan would be reviewed monthly and for a Resident with pressure areas, the wound care plan would be reviewed on a daily basis if required. This practice is accepted best practice for clients with complex medical conditions being nursed privately in their own homes I would expect all Registered Nurses to be able to comprehensively assess clients and develop appropriate nursing care plans. If the Nursing Agency's Registered Nurses were not able to conduct assessments and develop nursing care plans, the agency would need to implement training for the Registered Nurses and provide adequate support and supervision for the Nurses.

[Mrs A's] nursing care plan does not meet best and accepted practice. There is no evidence as to who developed this 'task list', nor any evidence of any assessments or original care plan in the documentation provided to me. There is evidence of one nursing review undertaken on the 03/03/01 by a Registered Nurse, there is no evidence of any of the nursing care plan. If [Mrs A] had resided in a private hospital, as promoted, her nursing care plan would have been relevant and professional. It is clear that [Mr B], Director of [the nursing agency], was responsible for [Mrs A's] wound care management and care plan. I find it gravely concerning that he did not complete a formal wound assessment and care plan with formal reviews, along with lack of referral to appropriate wound care specialists, Occupational Therapist and Dietitian for advice in management of [Mrs A's] pressure areas. I believe that this warrants further investigation at Governance level of [the nursing agency] and [Mr B's] competencies as a Registered Nurse.

6. *Was the staff ratio, and skill level, appropriate for [Mrs A's] needs at all times? In particular, was there adequate input from registered nurses?*

In my opinion, the staff ratio and skill level was not appropriate at all times and there appeared to be inadequate input from registered nurses. During [Mrs A's] stay in [the public hospital], she required 2-3 nurses to transfer her and walk her short distances. She had poor and deteriorating mobility due to '*painful, restricted right hip with x-ray indicating moderately severe osteoarthritis, generalized wasting and weakness in her legs, particularly proximally, a long standing left partial foot drop … Functionally through most of her admission she refused to stand by herself, complaining of giddiness which in fact is fear of falling*' ([Dr O's] discharge letter, dated 13/8/00). There is documented evidence in the [the public hospital] nursing progress notes of [Mrs A's] continued verbal and physical abuse of the nursing staff, which was challenging to the nurses who cared for [Mrs A]. [Dr O's] discharge letter, dated 13/8/00, documents [Mrs A's] problems as including '*1. Eccentric personality, 2. Probable mild dementia of frontal lobe type associated with abusive personality*', his letter also describes [Mrs A's] behaviour as '*She has been extraordinarily demanding in hospital, at times pleasant and witty but most of the time shouting instructions and abuse at the top of her*

voice, slapping nurses, turning the television up to full volume to attract attention'. The Occupational Therapist had documented (as above in point 4) that [Mrs A] was to be cared for by two caregivers, one of whom was to be a Registered Nurse.

[Dr O] comments in a letter, dated 22/5/01, written to the Welfare Guardian, [Mr J], '*I suspect her dementia has worsened as she has quite surprising memory difficulties for simple facts*'.

It is clear that [Mrs A's] nursing requirements were unique and more in line with the behaviour one could expect from Residents placed in dementia care. Staff who were rostered to care for [Mrs A] should have had training in challenging behaviour and dementia care in order to be able to better understand and manage her care, there is no evidence that the staff were in fact trained in either challenging behaviour or dementia care. It is also clear that [Mrs A] required 2 caregivers at all times for: lifting, transferring, walking (when able and willing), turning in bed, standing up from chairs and showering, this was necessary not only for [Mrs A's] safety and prevention of pressure areas from friction and shearing, but also as a safety measure for the caregivers, both physically and emotionally. With the reduction of caregivers from two full time to one full time with support from another caregiver in the mornings and afternoons/evenings meant that [Mrs A] would have been turned and transferred to the commode, etc by one caregiver frequently, if she was actually turned at all. It is clear from [the nursing agency] progress notes that [Mrs A's] caregivers were challenged at times by the restriction of one caregiver and had to resort to poor practice by leaving soiled sheets under [Mrs A] and trying to protect her skin with pads (as above, point 4). I do not believe that with [Mrs A's] challenging behaviour, probable dementing illness and immobility, one caregiver could adequately manage turns and transfers without assistance from another staff member, this raises the issue as to whether [Mrs A] was in actual fact, turned regularly 2 hourly as stated in [Mr B's] letter, dated 2/12/02, to the Health and Disability Commissioner, point 5 and given adequate care to meet even the basic bodily functions' requirements.

I also noted that [Dr O] comments in his discharge letter, dated 13 August 00, '*is to be discharged with 24 hour nursing care from [the nursing agency] … and rental of an adjacent unit as well*'. I question the use of the adjacent unit – was this intended for the nursing staff to sleep over? If this is the case, was this happening when there was only one caregiver on duty at night? How did [Mrs A] attract their attention when she required it, and did the caregiver set the alarm for every 2 hours to turn [Mrs A] as requested in her [nursing agency] progress notes? I also seriously question whether the rental of an adjacent unit was appropriate when [Mrs A] was clearly hospital level of care and it had been very clear in [the public hospital] nursing progress notes and care plan that she required 2 to transfer her, and her nursing transfer form on discharge from [the public hospital] stated '[Mrs A] *is a high risk for falls and requires 2 nurses to transfer*'.

In the matter of Registered Nurse input, it was expected by [the public hospital] that [Mrs A] would be cared for by Registered Nurses on a 24 hour basis. [Mr B] mentions

in his letter to the Health and Disability Commissioner that '*the staffing ratios were altered to have a registered nurse on duty 24 hours a day supported by a caregiver. This change was also run past [Dr O]*'. Although I was unable to find any evidence to back this, this staffing ratio was adequate, if the caregiver supporting the Registered Nurse was actually working 24 hours as well. However, [Mr B] goes on to say in his letter (as discussed above in point 4), the staffing ratios were further reduced to one caregiver full time with support from a second caregiver for mornings and afternoons/evenings. It is important to note that these caregivers were also expected to complete household tasks, such as '*prepare and serve meals, laundry, vacuuming, cleaning, rubbish and general tidying*'. There is no evidence that the caregivers were trained or certified in meal preparation. There is evidence that the caregivers lacked provisions and that one caregiver had expressed her concerns re [Mrs A's] diet (see above in point 4). There is little evidence of Registered Nurse input and it is difficult to determine from the entries in [the nursing agency] progress notes, whether a Registered Nurse was making entries. There is no clear nursing care plan (see above, point 5), review, or adequate instructions for care giving staff. There is clear evidence of documentation from caregivers regarding reddened areas, broken areas and pressure areas, these do not appear to be adequately followed up by Registered Nurses. [Mr B] mentions several Registered Nurses' names in his letter to the Health and Disability Commissioner, dated 2/12/02, I can find very little written documentation and proof of input on a regular basis from these Registered Nurses.

With the complexity of [Mrs A's] needs, she required input from a Registered Nurse on a daily basis. In my opinion, this staffing ratio was inadequate and inappropriate for [Mrs A's] needs.

Of grave concern to me, was the staffing roster, which indicated serious issues with availability of staff, the number of hours they worked on a duty and over a period of time. I note that [Ms K's] hours of work and number of duties per week over a period of time from 23/4/01 to 30/9/01 were excessive. Her hours per week ranged from 56.25 hours to 107.25 hours. [Ms K] worked in the 12 day period from Sunday 26/8/01 to Thursday 6/9/01 a total of 147.5 hours, this included six 16.75 hour shifts.

There were times where a staff member would work a 24 hour shift with 2 other staff members supporting her by working short shift in the morning or afternoon. (See roster.) On two occasions, the staff member working the 24 hour shift had a second staff member working both the short shifts (17/10/01, 19/10/01) and on one occasion, the staff member working the 24 hour shift had only 1 staff member support her by working a 3 hour shift in the morning (12/10/01). On the 12/10/01, there is an entry by [Mr B] stating '*continue with 2 hourly turns side to side and keep off back*'. It is difficult to see how a staff member who was working for 24 hours without a break, with one staff member supporting her for 3 hours in the morning, could adequately care for [Mrs A] and turn her 2 hourly as instructed without causing friction and shearing on the pressure areas that were present. My previous query (see above earlier in this point) in relation to the adjacent unit also raises the issue of when a staff member is working a 24 hour shift without a break, it would be natural for them to sleep in the adjacent unit, if

not, they would have been extremely tired. I question whether the care that [Mrs A] required and was requested of the caregivers by [Mr B] could possibly have been delivered.

In my opinion, the low staffing levels, the exorbitant number of consecutive hours worked by individual caregivers and the number of overall hours worked by individual caregivers on a weekly basis would have prevented the staff from delivering adequate and appropriate care to [Mrs A] and require further investigation at Governance level of [the nursing agency].

7. *Were resources (people and equipment) appropriately utilised in respect to [Mrs A's] needs?*

In my opinion, resources relating to people and equipment were not appropriately utilized to meet [Mrs A's] needs. [Mrs A's] pressure area risk had been assessed by [the public hospital] staff as being very high risk. The Occupational Therapist had documented the plan for 2 staff on at all times with one of them being a Registered Nurse; [Mr B], along with the Welfare Guardian [Mr J] and Property Manager [Mr I], made the decision to alter the staffing resources without [Mrs A] being assessed multi disciplinarily by the appropriate health professionals. In my opinion, [Mrs A] would have benefited by a full review from health professionals, eg Dietitian, Occupational Therapist, and a qualified Needs Assessor, in order to ensure that [Mrs A's] care and equipment were appropriate to her changing needs.

8. *Please comment on the liaison between [the nursing agency] and [Dr F]. Was it adequate?*

In my opinion, the liaison between [the nursing agency] and [Dr F] was inadequate given the complexity of [Mrs A's] needs and the development of the extensive pressure areas. [Mr B] states in his letter, dated 2/12/02, to the Health and Disability Commissioner that he '*requested [Dr F] also regularly examine these ulcers. [Dr F's] notes will* confirm *the steps taken in managing these ulcers*'. It is difficult to find any evidence to back these statements within [the nursing agency] progress notes. On examining [Dr F's] notes, I noted the following documentation 21/9/01 '*Phone [Mr B]*: *Afebrile today and much improved LOC – eating and taking antibiotics. Will provide daily wound cares and liaise re progress*'. 2/10/01 '*Script for Augmentin requested. Slight improvement*'. 8/10/01 '*Phone request for repeat script*'. 2/10/01 '*Phone request from [the nursing agency] nurse. [Mrs A] unable to take Panadol Tabs*'. 15/10/01 '*Rang [Mr B] [the nursing agency] – wounds healing satisfactorily. No major nursing problems*'. 25/10/01 '*Homecall …. Pressure ulcers still requiring treatment – no real improvement. General deterioration in overall condition. Having daily wound dressings from [the nursing agency]*'. In my opinion, [Dr F's] comments in his notes do not confirm any steps in managing the ulcers as [Mr B] claimed, nor do the entries from [Dr F] satisfactorily describe the pressure areas or their treatment. There is no evidence of liaison in relation to the pain that [Mrs A] must have been experiencing with such extensive and necrotic ulcers as described by [Dr O], [Dr R], the embalmer's report and graphically via the embalmer's photos. There is no evidence of any further liaison

between [Dr F] and [Mr B], [the nursing agency], after the 25/10/01, despite the obvious deterioration in [Mrs A's] condition.

The liaison between [the nursing agency] and [Dr F] commencing from [Mrs A's] return to her apartment under the care of both [the nursing agency] and [Dr F] appeared from [Dr F's] notes to be mainly in connection with phone call queries and script requests (28/9/00, 7/5/01, 7/6/01, 2/9/01, 2/10/01, 8/10/01, 12/10/01, 15/10/01). The home visits appeared to be (24/8/00, 4/9/00, 18/3/01, 13/6/01, 25/10/01). If indeed the home visits included only the 5 visits I could identify, the care from [Dr F] did not meet the standards expected by the Ministry of Health if [Mrs A] was a Resident in a private hospital, i.e. at least 3 monthly visits and more frequently as indicated clinically. The phone calls re queries and script requests had minimal information and does not demonstrate adequate liaison between [the nursing agency] and [Dr F] in relation to [Mrs A's] overall condition, behaviour and management.

9. *Please comment on the nursing treatment of [Mrs A's] pressure sores. Was this treatment appropriate?*

In my opinion, the nursing treatment of [Mrs A's] pressure areas was inadequate and inappropriate. [Mr B] appeared to be the Registered Nurse who was primarily involved with the pressure areas and their treatment. There is no evidence that a wound assessment chart was completed or a wound care plan developed and reviewed. [Mr B] states '*I sought the advice on more than one occasion from a nursing wound care specialist ([Ms S] from […] – who attended [Mrs A] at my request to examine and comment on the nursing treatment being used), advise from a wound care product supplier (Ebos) and requested [Dr F] also regularly examine these ulcers*'. I found an entry in the [the nursing agency] progress notes on the 1/10/01 relating to discussion with the 'Ebos wound specialist' and the wound products to use after the pressure area is documented as '*areas of erosion have increased*', Intrasite Gel and a hydrocolloid, covered with opsite was used the next day. I found no documented evidence of any review, visits or discussions with [Ms S] from […] as stated in [Mr B's] letter.

[Mrs A] must have been suffering severe pain from her pressure areas with the necrosis, depth, nerve ending exposure, and with the movement required just in turning her, transferring her and showering her. I would expect that Registered Nurses managing such open wounds as [Mrs A's] ulcers would have assessed, and reviewed on a regular basis, [Mrs A] for pain and subsequent pain management. In my opinion, such negligence in not completing a pain assessment and pain management care plan and regular reviews constitutes abuse and neglect and warrants further investigation into the competencies of the Registered Nurse(s) involved in [Mrs A's] care during this period.

Due to the lack of documented assessment and review of the pressure areas, it is difficult to tell whether the correct wound products were used. However, based on the photos taken by the embalmers, the embalmers' report on the size and depth of the pressure areas, the comments relating to one of the pressure sores being '*huge necrotic and incredibly offensive*' in [Dr O's] letter, dated 15 11/01, the wound care products documented as being used in [the nursing agency's] progress notes on the 14/11/01 as

intrasite gel, hydrocolloid and opsite, were inappropriate and inadequate for the pressure area. I believe that [Mrs A's] pressure areas should have been assessed and reviewed by a wound care specialist nurse, most likely being accessed from [the public hospital], on a regular basis when they failed to respond adequately to the treatment that [Mr B] was delivering.

10. Should [Mrs A] have been referred to the hospital for surgical review of her pressure areas? If so, at what point?

In my opinion, [Mrs A] should have been reviewed for surgical review of her pressure areas when they became necrotic. Due to the fact there is no assessment or ongoing review and documentation of the pressure areas with full description of what the pressure areas looked like or photos taken of the progress of the pressure areas, it is difficult to determine at exactly what point [Mrs A] should have been reviewed. More importantly, [Mrs A] should have been referred for wound specialist nurse advice and multi disciplinary review of the prevention and pressure area management by Occupational Therapists and Dietitian, at an early stage. These referrals should have been made when the pressure areas began to develop from broken areas before they enlarged to form cavities.

11. Should an assessment have been arranged to establish whether [Mrs A] required hospital level care? If so, whose responsibility was it to arrange this?

In [Dr O's] letter to the Family Court Judge, dated 18/4/00, he stated' *I support the Application for a personal order to*

1) retain [Mrs A] in [the public hospital] (or a private hospital in the [city] area) pending repatriation to [an overseas country].

2) transfer [Mrs A] from [the public hospital] to[a private hospital], [overseas]'

[Dr O] is quoted in (24) in the court order '*I still believe a property manager is essential and welfare guardian would best ensure her changing needs are met, e.g. a move to a private hospital if a trial discharge home fails*'.

[Dr O] states in his discharge letter, dated 13/8/00, '*She is keen to remain in [the city] in her apartment and is to be discharged with 24 hour nursing care from [the nursing agency] ……If this does not work out she may need private hospital care*'.

The [the public hospital] Nursing Care Plan and nursing progress notes all indicate that [Mrs A] required hospital level of care on discharge due to full assistance with ADLs (activities of daily living), 2 nurses to transfer and walk [Mrs A], the development of broken sacral areas and her incontinence of both urine and faeces.

With [Dr O] commenting on the need for private hospital care for [Mrs A] if the trial discharge home failed and the nursing care plan indicating hospital level cares, [Mrs A]

was already at hospital level of care and would only have required reassessment as an update of her needs in order to admit her into private hospital care.

I note that [Mr B] expressed his concern to the court '*that there be clear authority for his staff, including moving [Mrs A] into a private hospital if the need for that arose having regard to her medical condition*'.

In my opinion, [Mrs A] should have been referred for reassessment for hospital care when [the nursing agency] began to experience staffing difficulties, the staffing levels were reduced to one full time caregiver and one supporting staff member in the mornings and afternoons/evenings. [Mrs A] should definitely been referred for hospital care once she developed the pressure areas, when she began to lose weight and it became difficult for the care giving staff to manage her. Clearly the home 'trial' failed.

In my opinion, the responsibility for referring [Mrs A] for reassessment for hospital level of care firstly was the responsibility of [Mr B] when he and his agency were unable to adequately meet [Mrs A's] needs, the staffing levels as determined with [the public hospital] were not being met, and the development and rapid deterioration of the pressure areas, and secondly [Dr F] who should have recognized that the challenge of nursing [Mrs A], her weight loss, her deteriorating condition and the development and rapid deterioration of her pressure areas was too much for the care giving staff of [the nursing agency] and was in fact detrimental to [Mrs A's] welfare and safety. [Dr F] stated in his letter, dated 24/5/03, to the Health and Disability Commissioner '*She presented with problems that are difficult to treat in a community setting and combined with a dementing illness and aggressive manner she was an extremely professionally demanding patient*'. I believe that this comment made by [Dr F] does in fact demonstrate that he knew [Mrs A's] care requirements were extremely professionally demanding, and in view of this and the fact that she was being cared for by one full time caregiver with a second support caregiver (non professional staff) for a few hours in the mornings and afternoons/evenings, this knowledge combined with her evident weight loss and development of pressure areas, meant he should have referred [Mrs A] for reassessment for transfer to a private hospital.

12. Are there any other matters relating to professional or ethical standards which you believe are relevant to this complaint?

I believe there are other matters relating to professional or ethical standards, which need to be addressed.

- In my opinion, the follow up of [Mrs A] from Older People's Health was inadequate. [Dr O], the public hospital, commented in his letter, dated 18/4/00, to the Family Court Judge '*She would be capable of living at home with 24 hour nursing care*' and in his letter, dated 3/8/00, to the Family Court Judge '*discharging the former Personal Order to retain her in hospital and replacing this with a Personal Order to return home with 24 hour nursing care but allowing for transfer to a suitable private hospital should the situation break down at home*'. In a later letter, dated 11/9/00, to [Dr F], [Dr O] stated '*I called in to see [Mrs A] at home on 06/09/00 as*

part of our commitment to follow her up at intervals from Older People's Health'. In the letter [Dr O] wrote to [Dr F], dated 15/11/01, he stated '*I have not seen [Mrs A] for some months and noted a dramatic deterioration in her condition*'. The Occupational Therapist, […], made a home visit with [Mr B] ([the nursing agency]), [Mr H] (property manager) and […] (community Occupational Therapist), finalized arrangements and decided that further OT input was indicated. I have concerns as to how Older People's Health determined that [the nursing agency] could in fact deliver appropriate care to meet all of [Mrs A's] needs, e.g. nutritional diet. I would have expected input from [the public hospital] Dietitian regarding [Mrs A's] dietary needs, especially in view of her challenging behaviour and her erratic food intake, which was recorded, in her [public hospital] nursing progress notes. I also have concerns in the lack of follow up from a multi disciplinary approach from Older People's Health and the lack of formal follow up from [Dr O] in relation to the 'some months' prior to his visit on the 16/11/01 (letter is dated 15/11/01) and also in relation to [sic] there did not appear to be a review of the overall management of [Mrs A], namely in staffing level appropriateness, changing needs for equipment, weight loss that must have been evident and dietary input to meet nutritional needs.

- In my opinion, the Welfare Guardian did not discharge his duties towards [Mrs A] adequately as legally required to do so. The Family Court appointed [Mr J] as [Mrs A's] welfare guardian '*in respect of all aspects of her personal care and welfare relating to:*

  i) where she lives;
  ii) the medical advice and treatment required in respect of her physical and mental health;
  iii) the provision of support and services in respect of her daily cares including toileting, washing, food and mobility;
  iv) the cleaning, upkeep and maintenance of her residence;
  v) her move to alternative accommodation including as necessary a private hospital, rest home or other supervised accommodation;
  vi) whether she is to remain living in New Zealand or elsewhere'.

  [Mr J] documents in his notes, dated 21/12/00, '*We advised [Mr I] and [Mr H] of our resolution to take [Ms C] off [Mrs A's] roster early in the new year. This will happen as part of our ongoing process to reduce the cost of [Mrs A's] care. The caregiver team to be supervised by a RN and initially the RN will visit each day. If this seems successful the frequency of the RN visits will be reviewed*'. 4/1/01, '*I visited [Mrs A]. She was in a pretty agitated state. [Mrs A] is unhappy with [Ms L] and wants her removed from the roster*'. 8/1/01, '*Called [Mr B] this morning and we discussed the situation. He is up with the play and he will be visiting [Mrs A] today*'. 20/1/01, '*She clearly misses [Ms C] and is still not entirely happy with the nursing arrangements*'. 29/1/01, '[*Ms L] is in the dogbox again but otherwise things seemed pretty good*'. 5/2/01, '*She was giving [Ms L] a bit of grief today……[Ms L] said that she was always grumpy after her shower and that she wanted [Ms K] to stay on past the end of her shift*'. 8/2/01, '*[Mrs A] is still grumpy*

today. She cannot explain what is wrong or why she is so unhappy. Staff report that she has been quite uncooperative and difficult. I explained the need for her to maintain a routine to ensure the staff can manage as some tasks need two people and must be done during the shift overlay'. 23/2/01, '*[Mrs A] was pissed with [Ms L] again. I can't figure out what sets her off but clearly she doesn't like her*'. 5/3/01 '*she is still grumpy with the staff. I can't get to the bottom of this and she seems quite confused about what is wrong……but she is still unhappy*'. 14/3/01, '*Although she was quite sharp today she seemed quite sad and lonely*'. 20/3/01 '*Visited late afternoon and [Mrs A] was quite upset. She was certain she had soiled herself and was quite impatient for the evening shift to arrive so she could be changed. I helped [Ms M] to move [Mrs A] to the commode so she could have a movement. Her pad was clean and dry so she was upset over nothing*'. 23/4/01 '[…] *told me that [Mrs A] was getting a sore bottom and that going to bed earlier so she can be put her on her side would help the sore spot to heal*'. 11/6/01, '*She must have been having a battle with [Ms L] over something because she was not talking to her when I arrived*'. 15/6/01, '*She seemed to be quite agitated about something but we couldn't get to the bottom of it. I think [Dr F] had been in and she doesn't like him much*'. 3/7/01, '*[Mrs A] said she was sick of the food they were cooking … It is a battle to find anything she will eat at times*'. 14/8/01, '[*Ms L] has cut back her fingernails to the point where a couple are so short that they have been bleeding. This is the second time [Ms L] has cut her nails really short… I discussed this with [Ms M] …We are both concerned that this action seems a little extreme as none of the other staff have reported being scratched by [Mrs A]*'. 3/9/01, '*was not interested in food. This is a concern. …I was not able to talk her into eating anything*'. 6/9/01, '*they told me she is still not eating*'. 24/9/01, '*the pressure sore on her bottom had been improving a second pressure sore had developed. This was making it uncomfortable for her to sit up in her chair*'. 5/10/01, '*She still needs to stay in bed as her bottom is still too sore to sit on*'. 2/11/01, '*The new chair has arrived. This should allow [Mrs A] to be moved into the lounge during the day without damage to her slowly healing pressure sores*'. 12/11/01, '*[Mr B] phoned around 8.30 to say he was going to speak with [Dr F] about [Mrs A's] pressure sores. One was healing well while the other was still quite serious and [Mr B] some [sic] minor surgery may be appropriate*'.

I believe that the documentation that [Mr J] has made indicates that he did not adequately follow up [Mrs A's] concerns regarding [Ms L], despite evidence that she had cut [Mrs A's] fingernails so short on two occasions that they bled and he appeared concerned enough to discuss this with another caregiver; he did not take [Mrs A's] concerns regarding [Ms L] seriously even though she appeared to be the one staff member [Mrs A] did not get on with; he did not indicate that he ensured [Mrs A's] needs would be adequately met when he agreed to reduce the staffing levels as a cost cutting measure; nor did he indicate whether an alternative option to reducing staffing levels in order to reduce costs would be to care for [Mrs A] in a private hospital; he was aware that [Mrs A] had to wait for the second caregiver in order to be sat out on the commode in order to pass a bowel movement and that this delay caused her distress but did not appear to consider how the indignity of a

possible accident would affect [Mrs A]; he was concerned regarding her lack of appetite and non eating but he did not appear to follow this up with the doctor or [the nursing agency] or ask for dietitian involvement; he was aware of the pressure areas but did not adequately follow up and establish that they were in fact healing and why they were developing eg was this an effect following the reduced staffing levels and [Mrs A's] weight loss. I believe that [Mr J] was in breach of the Family Court Order and have serious concerns for the way he handled the situation.

- [Ms E] stated in her letter to the Health and Disability Commissioner, dated 21/7/03, '*In October 2001 I was approached by [Mr B] … to provide temporary cover over one weekend … I believe it was mid October. …I had not previously dealt with the nursing management of pressure ulcers and was concerned about ongoing management of pain, exudates and odour. I discussed my concerns with [Mr B] on the following Monday*'. [The nursing agency] progress notes by caregivers state '*[Ms E] came 2 check sores* (5/10/01) *[Ms E] came* (?) *did dressing @ 1500* (6/10/01) *[Mrs E] came changed [Mrs A's] dressing* (7/10/01). The progress notes also state '*[Mrs A] pressure areas are slowly improving. Well done to you all for your excellent efforts in keeping [Mrs A] off these areas. It's making a huge difference. Cheers [Ms E]'* (7/10/01). There is no evidence that [Ms E] assessed [Mrs A] for pain and recommended or commenced pain management. The medication records for the dates 5/10/01 to 7/10/01 do not show any pain relief medication given, apart from paradex 1 tablet at 0800 on the 7/10/01. On the 15/6/01, [Dr F] has written 'Current Medication…….paracetamol 500 mg x2 prn q4h…..digesic x2 prn q4-6hourly (instead of paracetamol for severe pain). On the 30/10/01, [Dr F] has written [Mrs A's] current medications, these also include the paracetamol and digesic. This implies that the caregivers had pain relief which could have been administered to [Mrs A] when she was in pain. The Registered Nurse, [Ms E], could have checked the current medication chart/script and requested the caregivers to either give regular paracetamol or digesic, whatever she felt was appropriate to the level of pain [Mrs A] was experiencing, I found no evidence that [Ms E] did in fact do this. If the current medications did not include either paracetamol or digesic I would have expected [Ms E] to have contacted [Dr F] to explain the pain and request that he write a prescription for appropriate pain relief for [Mrs A]. In my opinion, [Ms E] is in breach of the Nursing Council Code of Conduct for Nurses and Midwives 1995 Principle Two (2.2, 2.4) and Four (4.3, 4.6), this would incur disapproval from her peers.

- [Ms C] stated in her report, dated 19/6/03, 'My duties included writing and implementing care plans'. There is no evidence of any assessment or care plan development during the period that [Ms C] cared for [Mrs A]. I would have expected [Ms C] to have met best and expected practice by completing comprehensive assessments and care plans.

- [Ms D], Registered Nurse, stated in her letter to the Health and Disability Commissioner, dated 4/6/03, 'However I believe the care ([Mrs A]) deserved was compromised…I believe she should have had two people caring for her all the time.

This decision was made we were informed because of budgetary constraints'. 'I think it is unfair to expect the caregivers to carry out this responsibility. My other concern was the absence of the Property Managers or Guardian Welfare at this meeting to confirm this information as correct but we accepted this explanation without further ado'. 'It generally took two people to wash or shower ([Mrs A]) safely or even to change her position in bed … Sometimes she would accidentally soil herself and staff would have to wait until another staff member arrived before any thing could be done. …For me this was a safety issue and concern for both staff and client'. There is no evidence that [Ms D] expressed her concerns or followed up as an advocate for [Mrs A] by writing to any of the parties involved with [Mrs A's] care, eg [the nursing agency], welfare guardian, property managers, [Dr F] or [Dr O]. [Ms D] also stated in her letter that 'I would ensure pressure was not bearing down on these areas by positioning sand bags to keep her heels from touching the bed', the use of sand bags for this purpose is not best or recommended practice. I am unable to establish whether [Ms D] was caring for [Mrs A] during the time she would have developed her pressure areas, so cannot comment from this angle. I believe that [Ms D] has breached the Nursing Council Code of Conduct for Nurses and Midwives 1995 Principle Three (3.2, 3.5, 3.6), Principle Four (4.3, 4.5, 4.6), this would incur disapproval of peers.

- In my opinion, [Mr B], Director of [the nursing agency] and Registered Nurse, did not discharge his duties as Director of [the nursing agency] nor professionally as a Registered Nurse. [Mr B], in his role of Director of [the nursing agency], was responsible to ensure that there were adequate staff, correct and consistent staffing levels, adequate supervision of [Mrs A's] care, adequate staff training, adequate provision of supplies including food, financial charges in regards to all expenditures for [Mrs A's] care that was provided and to inform the Welfare Guardian, [Dr F] and [Dr O] when he felt that [the nursing agency] could no longer deliver the level of care that [Mrs A's] needs required. In my opinion, there were not adequate numbers of staff who cared for [Mrs A], this was clearly demonstrated by the number of 16 or 24 hour period duties consistently worked by the caregivers. The staffing levels were not consistent, ranging from 29.73 hours on the 20/10/01 to 47.25 hours on the 13/10/01, with the 'normal' number of hours worked being 32.75 hours. There does not appear to be any reason why the hours varied at times, apart from the period when [Mrs A] had septicaemia in September 01, this cost was obviously charged to [Mrs A's] property managers. There is notation of lack of supplies, including food, this is not acceptable in my opinion as this was denying [Mrs A] an adequate and nourishing diet. I question the ability of the staff to provide nutritious meals. I also question the quality and nutritional balance of the food provided as well as the variety and quantity available. In my opinion, I would like to see the financial charges by [the nursing agency] to [Mrs A's] estate during the entire period that [the nursing agency] was involved in her care be audited against the services provided as the amount documented in the statement by H attached to the lawyer's letter dated 25/6/02 states '[*Mrs A] paid [a significant amount of money] to [the nursing agency] for the period 18-8-2000 to 19-11-2001 for her care*'. This figure seems rather high, especially in view of the fact that the Registered Nurse staffing levels

were drastically reduced. I noted on two of [Ms C's] timesheets that she claimed $50.00 of parking fees, this is not common practice in the health industry. In view of the fact that I had difficulty determining when there was Registered Nurse input into [Mrs A's] care, on an ongoing basis, through the progress notes and roster and the lack of timesheets available to me, it would also be interesting to establish the correlation of the financial charges against Registered Nurse service hours charged.

In my opinion, [Mr B], as a Registered Nurse, must practise within the bounds of the Nursing Council's Code of Conduct for Nurses and Midwives, 1995. I believe that [Mr B] did not provide care to [Mrs A], which met professional standards using knowledge, skill and reasonable care required by a Registered Nurse, this would incur severe disapproval from peers. He did not complete assessments and develop adequate nursing care plans for [Mrs A] in relation to her daily activities of living, pressure area prevention and care, wound management and pain management. He did not ensure that [Mrs A] had access to an adequate and nutritious diet. He did not refer [Mrs A] to the appropriate health professionals for advice on management eg wound specialist nurse. [Mr B] did not acknowledge when the care delivered was inadequate for [Mrs A's] needs and refer her for reassessment for private hospital care. [Mr B] did not adequately keep the Welfare Guardian, [Dr F] and [Dr O] informed as to the severity of the pressure areas and in a timely fashion so that surgical/medical wound management advice could be sought. [Mr B] did not assess or manage [Mrs A's] pain and consequently [Mrs A] would have endured a great deal of pain during the last few weeks of her life. [Mr B] did not adequately supervise the caregivers, nor adequately follow up with concerns raised about individual caregivers by other caregivers, the welfare guardian or [Mrs A]. I believe that [Mr B] is in breach of the Code of Conduct for Nurses and Midwives, Principle Two (2.1, 2.2, 2.4, 2.7, 2.9); Principle Three (3.2, 3.5, 3.6); Principle Four (4.3, 4.4, 4.6). I believe that [Mr B] is in breach of The Code of Health and Disability Services Consumers' Rights: Right Three (dignity); Right Four (1,2,3,4,5); Right Seven (1, 2, 3, 8).

In conclusion, I believe that [Mrs A] was subjected to a severe form of abuse and neglect. She was placed by the Family Court under the protection of her Welfare Guardian and was cared for in her home by the [the nursing agency]. The court order gave the Welfare Guardian the power to make all decisions on [Mrs A's] behalf and the responsibility to ensure she was cared for at the level required either in her own home or in private hospital or rest home care. Instead [Mrs A's] care was compromised when a decision was made by [the nursing agency], [Mr J] and [Mr I] to reduce the staffing levels below the level she required for her safety and well being. [Mrs A's] nutritional needs were not considered and her dramatic weight loss was not followed up by her welfare guardian, [the nursing agency] or her GP [Dr F]. On the development of pressure areas, [Mrs A] received wholly inadequate care from both [the nursing agency] and her GP. It is well understood that wounds, such as [Mrs A's] pressure areas, can and usually are very painful and require careful and compassionate treatment in order to ensure that normal activities such as showering, and turning, as well as wound dressing do not cause excessive pain and

> discomfort. [Mrs A] had a deteriorating dementing illness, despite this she was able to indicate to everyone concerned in her care that there was something seriously wrong. It is sad to think that because [Mrs A] was known to have an eccentric personality and challenging behaviours, her obvious indications of discomfort, etc were clearly put down to this and ignored. In my opinion, the abuse and neglect that [Mrs A] suffered during the last few months, and particularly the last few weeks, of her life is totally unacceptable and against her human rights. I believe that this severe abuse and neglect warrants further investigation with follow up to the individuals who did not discharge their duties to [Mrs A]."

In view of the conflicting opinions of my nursing and general practitioner advisors, and in view of the concerns raised by nursing advisor Jenny Eastgate, further investigation was undertaken. Interviews were conducted with some of the staff members involved in Mrs A's care, and the reports set out above were obtained from Dr P and Dr O.

Further nursing advice
All of the above information, including the advice provided by Dr Turnbull and Ms Eastgate, was sent to a third advisor, Ms Jenny Phillips, an independent nurse practitioner (wound care). Ms Phillips advised as follows:

> *"1. What relevant standards apply in a case like this? In particular, are there standards that apply specifically to a community setting? Which standards about the responsibilities of registered and enrolled nurses are relevant in this case?*

Standards: The Health and Disability standards relating to consumer rights apply in this case, but additionally the following Nursing Council standards in relation to registered and enrolled nurses have in some way not been met. See Appendix A for the actual standards.

Principle 2.
The nurse or midwife acts ethically and maintains standards of practice.
I consider all of these were not met in some way, but particularly noticeable in terms of specific breaches are: 2.2; 2.3; 2.4; 2.7 and 2.9.

Principle 3.
The nurse or midwife respects the rights of patients/clients.
This principle is not easy to maintain for a person with mental impairment, but involvement of a specialist psychiatric nurse, and withdrawing [Mr B's] daughter from the care environment when her inappropriate behaviour became apparent and [Mrs A] obviously was upset by her presence, would have been a step in the right direction. I consider that 3.1 was specifically breached.

Principle 4.
The nurse or midwife justifies public trust and confidence.
Most serious breaches here relate to 4.3; 4.4; 4.6 and 4.9.

How all of the above have been breached is covered in the following answers, but in summary, the nurses were not up to date with the care issues relating to the type of patient they were caring for. [Ms E] and [Ms C] did not even know all of [Mrs A's] related health conditions, so it is difficult to see how they could decide what was normal and abnormal in her care and condition. Nursing records were non existent in terms of individualised care plans and documentation by registered/enrolled nurses. Lack of any type of team meetings/debriefing meant problems were not discussed and there was never an opportunity to look at the whole picture so that the obvious decline in [Mrs A's] condition could be recognised and acted on. It also meant that the caregivers were largely left to their own devices in a very difficult situation and did not appear to know where to address their concerns.

[Mrs A] was expected to conform to what the nurses wanted/expected in terms of meals and bed times, despite the fact that she was in her own home. This was even more so after staff were reduced to one caregiver for the majority of the time.

Community standards: I have contacted the Nursing Council and they admit that there is a regrettable gap in relation to patients nursed in their own homes by nurses, this does not however, mean they are not covered by the above principles which apply in all situations to all enrolled and registered nurses.

2. Please explain how pressure sores and foot ulcers develop. In particular, do they develop in patients who are turned two-hourly?

Pressure sores: These develop in individuals who have risk factors which predispose to their development and there are 3 main mechanical forces which can contribute; pressure, shear and friction. There is considerable debate over time and intensity of pressure and development of pressure sores, generally the more risk factors a patient has, the shorter time it will take for a pressure sore to develop.

Factors which help to prevent pressure sores developing are:

- Presence of collagen in the dermis
- Autoregulatory processes for maintaining tissue viability under pressure
- Way in which pressure is applied (i.e. not in a uniform manner, but located over boney prominences) (Australian Wound Management Association, 2001).

When pressure is applied at a level greater than diastolic blood pressure occlusion of the blood supply occurs. When the pressure is removed, redness of the skin occurs caused by the blood returning to the tissues, this is reactive hyperaemia and is the body's attempt to remove waste products and return oxygen to the tissues. This is a normal response showing the microcirculation is still intact. The main protective organ to pressure is skin because of the compensatory mechanisms above. When these are compromised, non blanching erythema occurs in which the reddened area remains red, and there is a finger tip test for this. Pressing lightly into the red area will show whether the area blanches or not, if it does not, then this is termed a Grade 1 pressure sore and signifies that pressure damage to the microcirculation has already started (Phillips, 1997).

(See also page 8 and flow chart on page 31 of the Australian Pressure Sore Guidelines attached for aetiology of pressure sores and related risk factors.)

The two hourly turning has no evidence base for this time. Pressure sores can develop in 30 minutes in highly compromised patients, others can be left for 4 hours, care should be individualised to the risk level of individual patients. Having said that, 2 hourly turns are the accepted normal practice in most areas, and were they regularly done, would reduce the risk of pressure sores developing, but more important is that staff are able to recognise Grade 1 pressure damage when it occurs and alter and plan care strategies as necessary.

Friction and shear are exerted when patients are dragged and not lifted properly, and these forces can tear the tissues.

Foot ulcers: If these are pressure ulcers, the aetiology would be the same, however, the appearance from the photographs is of ischaemic ulcers, and [Mrs A] was known to have vascular insufficiency as described in the medical notes. Ischaemic ulcers are caused by a reduction in arterial blood flow to the level where the tissues do not have enough oxygen and become necrotic (dry gangrene). This will happen regardless of whether there is any pressure to the area. This is usually an extremely painful condition which in the later stages is exacerbated by putting the legs up (such as in bed) as what little blood supply is available is reduced further, and tissues deprived of blood and oxygen cause severe pain.

3. Please explain how pressure areas and foot ulcers are prevented.

Pressure sores are prevented by carrying out a risk assessment on a patient and addressing all the **modifiable** risk factors contributing to the likelihood of tissue breakdown in the nursing care plan.

An essential part of the prevention process is reduction of the 3 contributory physical forces, friction, shear and pressure. Pressure can be reduced by reducing pressures (as occurs with some of the pressure equipment, such as padded cushions and foam mattresses) and/or pressure relief applied by turning patients or using alternating pressure mattresses. Friction and shear are reduced by correct lifting procedures.

Nutrition is a key element in the prevention of pressure sores as 'malnutrition, inadequate protein/hypoalbuminaemia or poor energy intake and recent weight loss have been identified in prospective and retrospective studies as independent risk factors' (AWMA, 2001 p. 10).

Other risk factors include moisture (from incontinence), faecal incontinence, immobility, and anything which compromises the skin (such as oral steroids). There is also debate around the relevance of all risk factors (AWMA, 2001).

Foot ulcers: In the case of ischaemic foot ulcers, prevention would rely on nursing staff recognising that a patient is at risk of reduced vascular supply and the symptoms of this

occurring, in particular pain. Presence or absence of pedal pulses are a simple indicator. Normally flushing of the tissues occurs before necrosis and this would be noticeable over a period of days before the necrosis. Referral should be made to a vascular surgeon for assessment of arterial occlusion and possible angioplasty, but if the early signs were missed, once necrosis occurred referral should occur rapidly if treatment is a considered option.

4. Was [Mrs A] at risk of developing pressure sores? Why?

[Mrs A] had already had a risk assessment in [the public hospital] showing her to be at very high risk (See page 800). One of her **biggest** risk factors once she left the hospital was that no one assessed her risk or provided a comprehensive nursing plan to reduce the modifiable risk factors. Interestingly [Ms E] was aware of risk factors such as nutrition (p198), and also later in her statement alludes to risk factors, yet she did nothing to instigate at formal process of risk assessment.

An extremely important factor was that even in the early days she was not in a nutritionally sound state (despite her obesity). She had a low serum albumin identified as early as July 2000 (page 917), this was an improvement on her April levels immediately after her severe illness, but still needed addressing. In June 2001 serum albumin was 28g/l, below 30 indicates malnutrition. This seems not to have been picked up by nursing or medical staff. Her B12 and Serum folates (P305) were low enough for the laboratory to query whether there was a poor diet or malabsorption yet apart from supplements of these, nothing was done about seeking nutritional advice. [Mr J] commented on her not eating in 2001 (page 330 and 331) and again page 334. In [Ms C's] statement (page 232) she states how [Mrs A] never ate a meal and at the end lost a lot of weight. [Ms E] (p195) states that 'she slowly did lose weight', and noted a dramatic difference in her condition from June to October, she refers to her as losing a great deal of weight and being 'shrunken in the bed', yet no action was taken. The nursing records show how her appetite decreased even further at the end of her life. [Dr O] described her as **extremely wasted** (page 281). I appreciate that she was not an easy lady to manage in terms of diet, but there was presumably no catering or nutritional expertise sought, nor did anyone suggest PEG or parenteral feeding at any stage until right at the end when it was far too late. In September 2001 there is one telling remark in the nursing record to give her fluids by syringe if necessary (page 422).

Despite her illness, I suspect her anaemia was also accelerated by the malnutrition. It dropped progressively from 133g/L on discharge to 94g/L in June (at which stage a transfusion could have been considered, and warning flags should have been raised) to 63g/L in October – a life threatening level.

The other major factors increasing her risk were:

Immobility – reducing her ability to move herself in the chair or bed
Inactivity – resulting in her sitting for longer periods without getting up
Incontinence – both urinary and faecal reducing the tensile strength of the skin, increasing maceration and risk of bacterial infection (AWMA, 2001).

5. *Were the measures taken by [the nursing agency] to prevent pressure areas and foot ulcers from occurring appropriate and adequate in the circumstances? If not, why not?*

Pressure:
Based on [the nursing agency] nursing notes provided, it would appear that there were problems in some areas. It is very difficult to judge what the measures were, given that the only nursing care plan is dated September 2001, and the only other nursing notes are progress notes. [Mrs A] does not appear to have had a comprehensive nursing assessment carried out at any stage, and especially on discharge home. Normally this would be the starting point for a nursing care plan to cover all her needs. In his letter of December 2002 (page 185), [Mr B] states that [Mrs A] was 'turned on bed, or repositioned in her chair at least every two hours'. I fail to see how he can say this, as it was not recorded in the progress notes, and would also have been impossible to achieve once the nursing staff levels were reduced (see also page 254 in [Ms D's] letter paragraph 28). [Mr B] also states that the pressure sores occurred over bruised areas, again, this is conjecture, as nowhere is the presence of these bruises documented.

In terms of equipment, I note the letter from the Occupational Therapist (OT) on August 8th 2000 (page 654) stating concerns that the equipment was not in place and that [Mr B] had agreed to supply a Roho cushion and pressure mattress. Unfortunately, she does not specify what sort of mattress, which is a major oversight, as there are wide variations from thick foam to state of the art electric, alternating pressure mattresses. I became totally confused about equipment, and there is no record of what was supplied. Some nurses refer to a padded cushion (which did not sound like a Roho cushion) and [Mr B] says she was sitting on a specialised cushion (page 187), but does not specify a Roho, so I suspect that she simply had a foam or padded cushion, the low end of the prevention range. There is mention of a ripple mattress (in [Ms C's] statement, page 244). It would be useful to know, if there was one, whether it was the old fashioned ripple mattress or an alternating pressure mattress, they are vastly different in terms of performance. The bed mattress was also changed to a Roho according to the letter from [Mr B], but again this does not appear in the nursing notes.

Roho mattresses are excellent, but they require constant adjustment on the initial set up so that they are individualised for a patient and then on an ongoing basis, as they lose air rather like bicycle tyres! This is not a difficult task, but one which needs to be taught and the OT would have been able to do this, but there is no mention that this occurred, so that if she did have a Roho, it is highly likely that it could have been incorrectly adjusted initially (over or under inflated) and then not maintained to provide ongoing pressure reduction. We may never know given the lack of documentation. As money was not an object, I wonder why the estate managers were not approached to fund an appropriate mattress and cushion on long term rental or purchase, both of which are possible. The singular lack of OT involvement advice regarding ongoing pressure relief management is unfortunate. [Mr B] states that OTs were involved (p186) but I can find no record of this after discharge.

I can find no documentation relating to the deterioration of the toes except for one entry on page 450 expressing concern, and a note of bruising on the right great toe on page 452, after which the toes were not mentioned again. Presumably while her heels were inspected and kept free of pressure sores, which is the one light in this story, her toes were not observed, and/or no one recognised the signs of arterial insufficiency. This begs the question of how often the registered nurses completed a nursing assessment to update their (non-existent) care plans. AWMA (2001) guidelines consensus statement is that 'individuals at risk of developing pressure ulcers should have a comprehensive skin inspection at least daily for signs of impaired skin integrity'. This inspection should take in the whole body, especially in someone like [Mrs A].

Shear and Friction:
As far as shear and friction forces were concerned, it is to be hoped that the nursing staff were taught how to lift properly and a hoist was brought in at some stage which would have helped. The use of barrier creams as described by all nurses and in the AWMA guidelines is recommended in incontinent patients, but the rubbing referred to, especially by [Ms C] as a preventative strategy, '*always massaged her bottom, not because she had pressure areas, but because you do that with everybody'* (page 241) has been discredited for a long time for contributing to tearing of susceptible tissues and breaking skin and shows how out of date her nursing practice and knowledge was (Phillips, 1997).

Nutrition:
[Mrs A] appears to have almost starved, or at least to have ended up malnourished and as already shown, this is a key element in prevention of pressure sores, and certainly in healing wounds once they have formed. It is somewhat ironic that the nursing progress notes consist almost entirely of what [Mrs A] did or did not eat, and yet at no stage was a fluid chart or 24 hour food diary kept to accurately assess her intake, nor was she weighed at any time, even when concern was expressed about weight loss. See also the answer to the previous question. AWMA (2001) consensus statement 'Maintain a balanced diet in individuals at risk. They should be assessed regularly and referred to a dietitian if their diet is inadequate'.

6. *Was the treatment of [Mrs A's] pressure appropriate? In particular, was her pain managed adequately?*

Treatment of pressure sore:
She needed correct equipment and nutrition as previously stated and once the wound was there, nutrition became even more important, by the time the wound was leaking large amounts, she would have been losing protein, which nobody involved in her care seems to have appreciated. Wound healing requires all nutrients, but protein, calories, vitamin C and Zinc are particularly important.

The only wound dressing mentioned is a hydrocolloid (incorrectly named by [Ms E], p 196). This is totally inappropriate for a heavily exudating wound and would have resulted in [Mrs A] being permanently wet, indeed as was stated, she sometimes needed the dressing changed twice a day, or when [Ms E] visited it was saturated after 24

hours. It did not seem to occur to anyone to change it to a more appropriate one. I would classify the wound nurse specialist who was involved as a nurse with some knowledge of wound dressings, and I hope she has changed her title. There are now several wound nurse specialists in New Zealand, and all of them would have picked up the multiple problems relating to the whole care of [Mrs A] (nutrition, equipment, referral on to other health professionals as well as provision of a more appropriate wound dressing). They would also have sharp debrided the wound if competent to do so, and recognised the need for this to occur.

Management of pain:
This is difficult to follow as there is no proper drug chart with the prescription written and then the administration on the same sheet. [Mrs A] had pain on discharge and from different sources throughout her illness. On discharge it was her left hand (p200, Dr O) for which she was prescribed Panadol 1G QID. It was **NEVER** given QID according to the drug chart and in fact the whole pain relief was very ad hoc as can be seen from nursing progress notes and drug chart. At no time did [Mrs A] have a **pain assessment** (such as the Wong Baker scale) or any attempt to find out what her pain levels were, what aggravated her pain, and indeed whether the analgesics worked when they were given.

At one stage in the records it was stated that pain was a main complaint (p 732) and then that she had a painful right hip (p735). On 3 Sept 2000 there was a request to give regular Panadol and Digesic which was done for 24 hours only, again without any evaluation. Paradex II was prescribed at one time, yet the records frequently recorded only one given. On the 15 September 2000 the records stated that she had a good night, and yet this was one of the nights when she was given analgesia at 4.00a.m. It is impossible to know what this was for, but given the state of her toes, it is highly likely that she had ischaemic pain by this time. In terms of her pressure sore, it is difficult to judge, but it would certainly have been painful when the wound was being dressed. I should imagine mobilising with her arthritis was constantly painful, and may well have contributed to her reluctance to do so, yet this does not seem to have been considered as a factor. Pain management fell far short of what [Mrs A] could have expected when in the care of registered and enrolled nurses.

7. *Was [Mrs A's] nursing care plan appropriate in the circumstances? In particular, was a nursing care plan necessary given [Mrs A] was being cared for in the community?*

This links back to much of the answer in question 4. There was no nursing care plan except for the very general one dated September 2001, and this did not constitute what normally is called a nursing care plan i.e. identifying a problem, documenting the nursing care/action to be carried out and then an evaluation of whether the action is effective. An example of a nursing care plan appears in [the public hospital] notes.

A patient receiving care from a registered nurse should always have a care plan, especially as this was 24 hour care and the agency was employed specifically for nursing

care. Even District Nurses provide a care plan for patients on daily or weekly visits where the problems and nursing plans are included.

8. *Was the staff ratio, and skill level, appropriate for [Mrs A's] needs at all times? In particular, was there adequate input from registered nurses, and adequate supervision of enrolled or caregiving staff*?

A major issue relating to staffing was that staff were not trained or updated in caring for the needs of [Mrs A]. [Mr B] refers to training in lifting and transferring in his statement, but these staff needed to know the best strategies for pressure sore prevention, and especially how to recognise Stage I pressure damage. Also how to carry out skin assessment and how to monitor diet and fluids and some indicators of what, when and how to report back to qualified staff.

The registered nurses and enrolled nurse were not up to date with pressure sore care or wound care, despite the wealth of literature which exists on these topics.

There was no visible supervision from the nursing notes, i.e. registered staff working with the other staff to see that they were doing things correctly, although as they did not know how to do this themselves, it would have been difficult. In particular the registered nurses have not met the direction and supervision requirements of the Nursing Council (see Appendix 2).

It is difficult to see how [Mr B] justified reducing the staffing because [Mrs A's] health was stabilising (p187) particularly as no formal assessment had been carried out, and all the nursing notes referred to lack of mobility, contractures and losing weight. See also the response to the next question.

9. *Were resources (people and equipment) appropriately utilised in respect to [Mrs A's] needs?*

See answer to question 5 regarding equipment. With regards to staff, I am not clear why staffing was reduced because she was improving (B, p187). It is difficult to see what this statement was based on given her reduced mobility, contractions, pain and poor nutrition.

Caregivers and registered and enrolled nurse cover would have been adequate if there had been a clearer understanding of responsibilities and the caregivers in particular had been educated in:

Correct use of equipment
Correct pressure prevention strategies (not massaging!)
How to identify a Stage 1 pressure sore
How and who to report concerns regarding care. i.e. delegation and supervision

It appears a physiotherapist was only involved for the chest infection in June, but then implemented some passive physio to [Mrs A's] contracted limbs. This should have been started much earlier.

After the initial involvement, the OT was not consulted again, despite the knowledge they have on pressure prevention equipment.

A dietician, a key person was never involved.

All the registered nurses were RGN or RGON, not one of them was a Registered Comprehensive Nurse and yet, no psychiatric input was sought, which I find a major oversight with [Mrs A], especially given the problems that were being encountered by the staff.

10. *Should [Mrs A] have been referred to the hospital for surgical review of her pressure areas? If so, at what point?*

This is a difficult question to answer and it would depend on the objectives for doing this. Normally surgeons are involved in debridement of pressure sores which have become very necrotic or sloughy, but it is of no value to do this unless all the other key issues are addressed, particularly nutrition. They may have instigated transfusions, PEG feeding (or total parenteral nutrition) and review of her general condition if she had been referred. I think this is a decision that would be made by a member of the medical staff, and I am not clear whether they actually saw the pressure sores or were going by descriptions given to them by the nursing staff, which may explain the lack of action.

11. *Is there a professional expectation for registered nurses to raise any concerns they have about the adequacy of their patients' care? Please provide comments.*

Yes, and these are covered by 4.3, 4.4 and 2.3 of the Nursing Council Principles (Appendix 1). There was a distinct lack of accountability by all the registered nurses in the care of [Mrs A]. This is also covered in other answers relating to the whole episode.

12. *Is there a professional expectation for enrolled nurses to raise any concerns they have about the adequacy of their patients' care? Are the expectations of an enrolled nurse different from the expectations of a registered nurse in this regard?*

Yes, they are covered by the same principles as a registered nurse in terms of raising concerns, however, the Registered nurse is responsible for supervision and delegation (see Appendix 2). In this case the supervision would be indirect which means that the registered nurse is available for access and ensuring that the EN knows however, when or where to obtain assistance or direction (Nurses Act, 1977).

13. *Please provide comments about the responsibilities [Ms E] had in her role as a registered nurse 'providing cover'. Specifically, please advise:*

    a) *should she have had a role in either establishing or maintaining existing care plans? If so, when?*

b) should she have raised concerns about the level of care being provided for Mrs A at any stage?

All registered nurses should be responsible for establishing and/or maintaining care plans, especially where they identify shortfalls, or a change in the condition of the patient. This case is significant for the lack of nursing records by any of the registered nurses (except [Mr B] when the dressings were changed). There were no records written by [Ms E] of the visiting 'wound nurse specialist'. This is a direct breach of 2.9 of the Nursing Council Principles.

The comment by [Ms E] (p193) that she was not responsible for clinical decisions is an indication of how little she understood about her role as a registered nurse. See the response to question 11 regarding raising concerns, but as she appears to have been the one person who recognized pressure sore risk factors and the weight loss and was shocked at the pressure sores, it was particularly incumbent upon her to act on behalf of [Mrs A] who could not speak for herself.

14. Are there any other matters relating to professional or ethical standards which you believe are relevant to this complaint?

All nurses breached principles 4.6 and 4.9 of the Nursing Council Code, whether they intended to or not. The whole of the direction and supervision policy was breached. This is a case which makes harrowing reading and there was a total lack of assessment, planning and implementation of nursing care which is the basis for all nursing care, decisions and records.

Training was not given in specific areas needed for caring for [Mrs A] (such as recognition or Stage 1 pressure damage), and none of the registered nurses were up to date with pain management or pressure area care or the importance of nutrition to health.

Documentation was substandard, and there was no formal reporting mechanism for all staff.

All registered and enrolled nurses involved in this case need to attend study days on professional and ethical issues as a minimum to ensure that they are aware of their responsibilities in any future situations."

In a covering letter attached with her report, Ms Phillips advised me:

"… I have also included the Australian Pressure Sore Guidelines[4] which should shape practice for the future. While I realise that these were not available at the time that [Mrs A] was receiving her care, the wealth of references shows just how much has been

[4] Clinical Fracture Guidelines for the Prediction and Prevention of Pressure Ulcers, March 2001. Australia Wound Management Association, Pressure Ulcer Interest Sub-committee.

written on the subject of pressure sores. New Zealand is behind the rest of the world in getting to grips with this problem, mainly because we do not have litigation on the same scale, but this does not excuse nurses in areas where pressure sores are a particular risk, such as care of the elderly and/or immobile from updating as it is a key element of the nursing care. This is particularly covered by Principle 2 of the Nursing Council Standards …"

Code of Health and Disability Services Consumers' Rights

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

RIGHT 3
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

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

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 7
Right to make an informed choice and give informed consent

8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

Professional Standards

The following professional standards from the Nursing Council's 'Code of Conduct for Nurses and Midwives' are applicable in this case:

Principle Two

The nurse or midwife acts ethically and maintains standards of practice.

Criteria

…

2.2 uses knowledge and skills for the benefits of patients/clients/community;

2.3 is accountable for practising safely within her/his scope of practice;

2.4 demonstrates expected competencies in the practice area in which currently engaged;

…

2.7 maintains and updates professional knowledge and skills in area of practice;

…

2.9 accurately maintains required records related to nursing or midwifery practice.

Principle Three

The nurse or midwife respects the rights of patients/clients.

Criteria

The nurse or midwife;

3.1 acknowledges and allows for the individuality of people;

…

Principal Four

The nurse or midwife justifies public trust and confidence.

Criteria

The nurse or midwife:

…

4.3 uses professional knowledge and skills to promote patient/client safety and wellbeing;

4.4 reports to an appropriate person or authority any limitations in professional expertise or personal health status or circumstances which could jeopardize patient/client safety;

…

4.6 takes care that a professional act or any omission does not have an adverse effect on the safety or wellbeing of patients/clients;

…

4.9 acts in ways which contribute to the good standing of the nursing and midwifery professions."

Opinion: Breach – Mr B

Summary
Under Right 4(1) of the Code, Mrs A was entitled to have services provided to her with reasonable care and skill. In my opinion, the services provided by Mr B in relation to pressure area prevention and management fell far short of this requirement.

Mr B was responsible for different aspects of Mrs A's care in his dual roles as both manager responsible for Mrs A's care for the period of the nursing agency's involvement, and as a registered nurse with primary responsibility for Mrs A's day-to-day care from August 2000.

In his role as manager, Mr B was responsible for ensuring an appropriate overall standard of care. This included responsibility for putting in place adequate and appropriate numbers and skill mix of staff to ensure that a safe and appropriate level of care could be provided, and that Mrs A's dignity and independence was respected. He also had a responsibility to ensure appropriate referrals were made to provide backup and support for frontline staff, adequate staff training took place, and that appropriate rostering decisions were made, relating both to the suitability of individual staff members, and the number of hours they worked.

As both a manager responsible for the provision of her care, and a registered nurse, Mr B was also responsible for ensuring that appropriate care planning decisions were made and documented, including the provision of a comprehensive initial assessment and plan for Mrs A's care. He was required to ensure that appropriate equipment was purchased. He also had a responsibility to accurately report Mrs A's condition to other key caregivers involved in Mrs A's care, including her general practitioner, in order to seek their support in providing an appropriate level of care.

In his role as a registered nurse, Mr B was additionally responsible for providing appropriate treatment to Mrs A when her pressure areas started to develop, by initiating appropriate further assessment and review, and ensuring that her pain was appropriately managed.

I acknowledge that Mrs A was not an easy person to care for. It is noted that Mrs A was often not compliant with her cares, which doubtless impacted on the management of her pressure area care. However, this does not excuse the significant omissions and overall failure to take appropriate measures to prevent and manage Mrs A's pressure areas.

The care provided to Mrs A was characterised by a lack of planning. Mrs A had already been assessed at the public hospital with a pressure risk score of 29, indicating a "very high risk" of pressure sore development. As stated by my nurse practitioner advisor, Ms Phillips, once Mrs A left hospital, one of her biggest risk factors was that "no-one assessed her risk or provided a comprehensive nursing plan to reduce the modifiable risk factors". This risk was compounded by the decision to progressively cut back the numbers and skill level of the staff to a level that was, according to my nursing advisors, detrimental to Mrs A's safety and wellbeing, and to the staff who were caring for her. The lack of appropriate training and support for staff working with a particularly challenging consumer, and the lack of appropriate communication with both the caregiving staff and other key players involved in Mrs A's care, including her general practitioner, were also risk factors.

In my view, from June 2001, when the nursing involvement in Mrs A's care reduced to what appears to be occasional unrostered visits by a registered nurse, and there was frequently only one inadequately trained caregiver on duty, who had sometimes worked for excessively long hours, the risk to Mrs A had increased to a point where the development of severe pressure sores was almost inevitable.

The combination of all of these factors led to substandard care that amounted to a breach of Right 4(1). The factors that contributed to the development of Mrs A's pressure areas and ulcers are outlined in more detail below. I will first consider aspects of the care provided by Mr B in his role as manager, then in both of his roles, and finally in his role as a registered nurse.

Adequate staffing for safe care

Although the exact dates of changes are uncertain because of lack of documentation, the number of staff caring for Mrs A ultimately reduced from two full-time staff, including a nursing staff member at all times, to a single caregiver with several hours of support from another caregiver in the mornings and evenings. Mr B advised me that a registered nurse "normally visited four or five times per week to monitor Mrs A's condition", although this level of nursing involvement is not reflected in the progress notes.

In his role as manager, Mr B had a responsibility to provide an adequate and appropriate skill mix of staff to ensure a safe and appropriate level of care was maintained throughout the period Mrs A was in the care of the nursing agency. This was particularly necessary given Mrs A's challenging behaviour and significant risk factors for pressure area care management. My advisors both confirmed that in his role as manager, Mr B was responsible for ensuring there were adequate staff.

The decision to reduce staffing numbers and skill level to the point where Mrs A was frequently in the care of a single caregiver was clearly inappropriate. Mr B advised me that this decision was made in conjunction with one of the property managers (Mr I, now deceased) and the welfare guardian. However, I accept the advice of Mr H that in his role as property manager, Mr I played no role in relation to welfare decisions for Mrs A, and there is no evidence to indicate that he was involved in the decision to reduce the staffing numbers. There is also no evidence of any input into the decision by frontline caregiving staff or by the other health professionals involved in Mrs A's care. In fact, the proposed staffing reductions were inappropriate because, as stated by Ms Phillips, they were "below the level required for Mrs A's safety and wellbeing". As stated by Ms Eastgate, Mr B was obliged to inform the other parties if the nursing agency could no longer deliver the necessary level of care.

Mr B justified the staffing cutbacks by stating that Mrs A's health was stabilising. Ms Phillips advised me that it is difficult to see how he could say that when "no formal assessment had been carried out and all the nursing notes referred to lack of mobility, contractures and losing weight".

It is repeatedly documented that Mrs A always required two caregivers for moving from her bed and transfers, as well as for turning in her bed. Ms Eastgate stated that this was necessary "not only for Mrs A's safety and prevention of pressure areas from friction and shearing, but also as a safety measure for the caregivers, both physically and emotionally". The reduction in caregiving staff meant that "[Mrs A] would have been turned and transferred … by one caregiver frequently, if she was actually turned at all."

Ms Eastgate commented that with the complexity of Mrs A's needs, she required input from a registered nurse on a daily basis.

The reduction in staff to unsafe numbers was inconsistent with professional standards and amounted to a breach of Right 4(2) by Mr B.

Adequate staffing to respect dignity and independence
Under Right 3 of the Code, Mrs A was entitled to have services provided in a manner that respected her dignity and independence as an individual. In his role as manager responsible for Mrs A's care, it was Mr B's responsibility to ensure this occurred. However, the decision to reduce the staff to a level where there was sometimes only a single caregiver present, meant that at those times Mrs A was unable to be moved or assisted to the toilet, because of her mobility problems and pressure area risk. This led to situations where her dignity and independence were not respected.

Ms D advised me that if Mrs A soiled herself, she would sometimes have to be left until another staff member came on duty. Ms G, who cared for Mrs A on night duty, said that sometimes Mrs A would want to get up to go to the toilet during the night and her request would have to be refused. Ms G was in the position of having to continue to respond to Mrs A's requests to get up by saying that it was not possible. On another occasion, Mr J recorded that Mrs A was quite upset because she believed she had soiled herself. He noted she "was quite impatient for the evening shift to arrive so she could be changed". In these

circumstances, I do not find it surprising that Mrs A was "feel[ing] out of control and very frustrated". Clearly, Mrs A's dignity could not be respected in such an environment.

Prior to the onset of her dementia and mobility problems, Mrs A had always lived independently. The fact that she was so vigorously opposed to having care provided for her in the first place suggests her independence was very important to her. While she had been declared incompetent to manage her own affairs, it was still important that she be allowed to maintain as much independence as possible, provided that her safety and welfare were not compromised.

In my view Mrs A's right to independence was not sufficiently respected. For example, Ms G advised me that if there were not sufficient staff on duty, Mrs A was not always permitted to decide her own bedtime. Mrs A would sometimes need to be put to bed at 9pm, although she had wanted to stay up until 11pm, if the relieving caregiver was rostered to finish work at an earlier time. This would sometimes result in a scenario of Mrs A "fighting them" to be allowed to stay up longer.

I acknowledge that Mrs A was often reluctant to retire at night, and that it would not have been appropriate to agree to a request to stay up all night, due to increased pressure area risk. However, this was not the reason that Mrs A was sometimes forced to retire at 9pm. The situation resulted from the staff cutbacks instigated by Mr B. The situation was clearly unsatisfactory, and did not respect Mrs A's rights to dignity or independence. In the circumstances, Mr B breached Right 3 of the Code.

Lack of staff training

Although there is no documentation of the staff training that occurred, Mr B advised me that all caregivers were trained in correct lifting and transfer techniques.

Ms Phillips advised me that the training described by Mr B was inadequate in the circumstances. In particular, staff needed to know the best strategies for pressure sore prevention, how to carry out skin assessment, how to monitor diet and fluids, the correct use of equipment and "what, when, and how to report back to qualified staff".

Ms Phillips noted that an important pressure sore prevention strategy is the ability to test for "stage one pressure damage", and explained how to perform a "fingertip test" to assess whether stage one damage had occurred. Ms Phillips explained that although two-hourly turns are the accepted normal practice for pressure area prevention, pressure areas can develop in a shorter or longer time depending upon the degree to which the area at risk is compromised. Care should be individualised, and a more important key to prevention than the regularity of turns is the ability of staff to recognise and respond appropriately to stage one pressure damage.

Ms Eastgate also suggested that the staff who were rostered to care for Mrs A should have had training in challenging behaviour and dementia care.

It was Mr B's responsibility, as manager, to ensure that necessary training was provided to staff. By providing insufficient training, Mr B did not meet professional standards and breached Right 4(2) of the Code.

Inappropriate rostering decisions
Staff rostering was completed by Mr B in his role as manager. Ms Eastgate expressed her concern at the apparently long hours worked by some of the staff. The records indicate that in the several months prior to Mrs A's death, it was not uncommon for one caregiver in particular to work in excess of 100 hours per week. There are instances of staff working 24-hour shifts with relief for only several hours in the morning or early evening. Ms Eastgate highlighted one day when a caregiver worked a 24-hour shift with support for only three hours in the morning.

Ms Eastgate advised me that the hours worked by the staff were of "grave concern" to her. She pointed out that during the same time period that staff were working 24-hour shifts largely on their own, Mr B had recorded in the nursing notes "continue with 2 hourly turns side to side and keep [Mrs A] off back". I share Ms Eastgate's concern that one caregiver, working for 24 hours with minimal breaks, would have been unable to achieve this without causing friction and shear, possibly exacerbating Mrs A's pressure sores. Ms Eastgate also advised me that the weekly hours worked overall by staff "would have prevented the staff from delivering adequate and appropriate care to [Mrs A]".

This was incompatible with safe nursing care, and amounted to a breach of Right 4(2) of the Code.

Failure to remove problematic caregiver from the caregiving environment
Under Right 7(8) of the Code, Mrs A had the right to express a preference as to who would provide her care, and have that preference met where practicable. Despite her dementia, on 4 January 2001 Mrs A was able to express directly to Mr J, her welfare guardian, her request for one of the caregivers, Ms L, to be removed from caring for her. Mr J appropriately informed Mr B of Mrs A's request, but there is no evidence that any action resulted. The matter was again brought to Mr B's attention on at least one other occasion, after an incident in August 2001 when Ms L had cut Mrs A's fingernails so short that they bled. However, Ms L remained on the roster until Mrs A's death. As manager responsible for rostering decisions, it was Mr B's responsibility to meet Mrs A's preference about who provided her care, when it was practicable to do so.

If Mrs A had been making multiple requests for the removal of different staff members, it may not have been practicable or reasonable to accede to her requests. The reason that the court order was necessary in the first place was to prevent Mrs A from immediately dismissing the staff members who were there to care for her. However, this was not the case. Mrs A made a single request about one caregiver. In my opinion Mrs A's request should have been taken seriously for two reasons.

First, it had been noted by other staff members, as well as by Mrs A's welfare guardian, that Ms L was not good at managing Mrs A's difficult behaviour. Ms C advised that Ms L would aggravate Mrs A's aggressive outbursts by "screaming back". In June 2001, Mr J

noted that "[Ms L] is not as good [as the older caregivers] at managing [Mrs A]. Perhaps this is something that [Mr B] should consider." There is evidence that both Mr J and Mrs A brought this situation to Mr B's attention. It is unclear whether, or to what extent, the nursing or caregiving staff discussed the situation with Mr B, but it is clear that the staff who regularly worked with Mrs A were aware of the situation and could have discussed it with Mr B if their views had been sought.

The second reason this matter needed attention was that, according to the diary notes of the welfare guardian, the problems in her relationship with Ms L caused Mrs A to be upset on numerous occasions. Mrs A was a disability services consumer, receiving services in her own home. The needs of disability consumers are often long term and lifelong. Continuing service needs are the reality of life for many such consumers, who require services for their daily functioning – there is no endpoint. For this reason it was particularly important that an avoidable problem, which was causing ongoing upset to Mrs A, was resolved.

My nursing advisors both advised that it would have been appropriate for Mrs A's concerns about Ms L to be followed up. Ms Phillips considered that the failure to remove Ms L in these circumstances was a breach of Principle 3 of the Nursing Council standards. I accept my expert nursing advice that Mr B's failure to remove Ms B was also incompatible with professional standards. Accordingly, Mr B breached Rights 4(2) and 7(8) of the Code by his failure to remove Ms L from the caregiving environment.

Care planning
Care planning is fundamental to the safe and appropriate provision of nursing care. Mr B was responsible for ensuring that adequate care planning occurred, both in his role as manager and as a registered nurse. Care planning includes ensuring that appropriate nursing documentation is completed and acted upon, and that appropriate referrals are made.

Planning and documentation
As both a manager and a registered nurse, Mr B was responsible for ensuring that appropriate plans for Mrs A's care were put in place and documented in her notes. He also had a responsibility to manage Mrs A's pressure area care by adopting appropriate prevention strategies. There is no evidence that a comprehensive nursing assessment or a care plan was prepared by Mr B, either at the time of Mrs A's hospital discharge or at a later date. Mr B advised me that "a regularly updated care plan was always in Mrs A's apartment attached to the fridge". There is no evidence of such a document in the nursing agency records.

There is an undated document entitled "Daily duties for Caregivers", which is primarily a domestic task list. There is also a document dated 13 September 2001 entitled "Updated Care Plan", although there is no evidence of a preceding care plan. Both my nursing advisors commented that the 13 September document was inadequate as a care plan. Ms Eastgate stated that this document did not include any pressure area prevention measures and was "wholly inadequate" as a care plan. Ms Phillips states that it "did not constitute what is normally called a care plan ie: identifying a problem, documenting the nursing care/action to be carried out and then an evaluation of whether the action is effective".

My advisors expressed concern that a comprehensive nursing assessment was not completed at any stage, particularly when Mrs A was first discharged to the care of the nursing agency. Ms Eastgate advised that best practice for clients being nursed privately in their own homes is the same as for consumers in residential care – a comprehensive nursing assessment is completed on arrival/admission, which is used to develop a comprehensive nursing care plan within three weeks. This is then reviewed at regular intervals, with a greater frequency of reviews required for residents with high risk or complex needs, such as Mrs A.

Ms Eastgate also advised me that because of the unclear and inadequate documentation, any returning staff would not readily have known about any changes in the care required for Mrs A, unless they were updated verbally.

Mr B's failure to complete and document adequate nursing care plans and assessments himself, with appropriate reviews, or to delegate the responsibility to another registered nurse, was inconsistent with professional standards and amounted to a breach of Right 4(2).

Lack of appropriate referrals

As manager, Mr B had a responsibility to provide adequate backup and support for frontline staff, particularly in relation to pressure care management, through ensuring the appropriate provision of equipment and that appropriate referrals occurred. In my view, once Mrs A was discharged from the public hospital to the care of the nursing agency, the primary responsibility to ensure that appropriate referrals were made fell to Mr B. Appropriate referrals would have included nutrition advice, patient management techniques, physiotherapy and/or occupational therapy involvement, pressure area prevention and wound management and, ultimately, reassessment by a qualified needs assessor.

Mrs A's apartment was assessed by an occupational therapist (OT) from the public hospital prior to her discharge and prior to any equipment being set up. Mrs A also had several visits from physiotherapists, a podiatrist, and a community nurse dating from August 2001, and she was ultimately seen by a palliative care specialist. Aside from visits by Dr F and Mrs A's geriatricians, there are no other documented visits from health professionals.

My nursing advisors both expressed concern at the lack of appropriate referrals in this case. In particular, both noted that no referral to a dietitian occurred. This was a significant omission because there are frequent references to the difficulties staff experienced preparing food that Mrs A would eat. Further, Ms Phillips advised that despite her initial obesity, there is evidence that Mrs A was not in a nutritionally sound state, even prior to her discharge from hospital. Nutrition, including adequate protein intake, is a key element in the healing and prevention of pressure sores.

There was also no further involvement from an occupational therapist after the initial OT assessment several days prior to Mrs A's discharge. Prior to this assessment, the OT had noted that Mrs A was to be cared for at home by two full-time caregivers including one registered nurse, on a trial basis only. This was the basis on which she made her assessment. At the time of her home visit, the OT noted that the necessary equipment for Mrs A was not yet in place. Mr B organised the initial equipment without further OT input, and failed to

seek further OT advice on the correct pressure area prevention equipment as Mrs A's mobility decreased.

It is difficult to establish exactly what pressure area prevention equipment was used because of the lack of documentation and the vague and varying accounts provided by those caring for Mrs A. However, it seems unlikely that Mrs A was provided with optimal equipment. It is unclear whether Mrs A was initially provided with a Roho cushion as recommended by the OT. On 25 September 2001, Mr B instructed staff to use a "hospital bed ring" when Mrs A was in her bed or chair. According to my nursing experts, this is now outdated practice and can cause pressure sores to develop. Mr B advised me that the ripple mattress used by Mrs A was replaced by a Roho mattress, as recommended by Dr O. This did not happen until 15 November 2001.

My nursing advisors also commented that when Mrs A's pressure sores started to develop, the wounds should have been assessed by a wound specialist. Mr B advised me that he did seek advice from a nurse wound specialist, Ms S. However, Ms S advised me that she is not a wound specialist – she has had no special training in the treatment of wounds such as Mrs A's, and her job title was "community nurse". Ms S was not appropriately qualified to give wound care advice.

Ms Phillips also noted that earlier physiotherapy involvement would have been beneficial for Mrs A's contracted limbs. Although the dates of physiotherapy referrals are confusing because of incomplete documentation, it appears that referrals were made in August 2001 and November 2001. According to Ms Phillips, the physiotherapy intervention did not occur early enough.

Ms Eastgate stated that Mrs A would have benefited from a full review by a qualified needs assessor. Ms Phillips also noted that psychiatric input would have been very useful to assist staff with the management of Mrs A's difficult behaviour, and I note that Dr O also made this observation.

I have also noted the comments made by Dr P and Dr O with regard to the need for referrals for Mrs A. Dr P suggested that depending on the level of expertise of the caregiving team in the management of Mrs A's foot ulcers, a referral to an ulcer nurse or the Ulcer Clinic may have been appropriate. Dr O commented that because of Mrs A's risk factors, intermittent review by a dietician, physiotherapist and specialist ulcer nurse were warranted throughout her time at home. According to Dr O, "This attention certainly occurred in public hospital but broke down on discharge home."

Mr B clearly did not consider a referral to an ulcer nurse or the Ulcer Clinic. By his own admission, he was not aware of the ulcers on Mrs A's feet despite his role as the manager and registered nurse in charge of her care from August 2000.

In not ensuring that appropriate referrals were made throughout the 15-month period Mrs A was at home, and in not ensuring that appropriate equipment was in place, Mr B breached Right 4(2) of the Code.

Accurate reporting of Mrs A's condition

Mrs A had the right to co-operation among providers to ensure quality and continuity of care. In his role as manager, Mr B had a responsibility to accurately report Mrs A's condition to her other key caregivers – particularly her general practitioner, her geriatricians, and her welfare guardian and property managers, in order to seek their support and co-operation in providing appropriate care for Mrs A. He also had a responsibility to act as an advocate for Mrs A, in respect of communication with others involved in her care, in his role as a registered nurse. For example, it was necessary for other parties to have accurate information in order to understand the continued need for high level support and/or to involve other providers in Mrs A's care, or to arrange for her reassessment and ultimate hospitalisation, if appropriate.

In my view Mr B did not effectively co-operate with Mrs A's caregiving staff, her general practitioner, or other professionals involved in her care.

Mr B advised me that the decision to cut back the number of staff caring for Mrs A was made in conjunction with the welfare guardian and one of the property managers (Mr I). Mr H denied that Mr I had any involvement in welfare decisions. There is no evidence that Mr B discussed the proposal with any of the staff who provided "hands on" care to Mrs A. A number of the caregiving staff believed that Mrs A's care would be compromised by this decision, yet their opinions were not sought by Mr B at the time of the changes. Mr B should have discussed any proposed staff cutbacks with the caregiving staff involved, in order to assure himself that safe care could still be provided.

Furthermore, although Mr B advised that the first staffing reduction (to "a registered nurse on duty 24 hours a day supported by a caregiver") was "run past Dr O", there is no evidence that any of the subsequent cutbacks were discussed at any stage with either Dr F, Dr P or Dr O. As a result, when Mrs A's condition started to deteriorate and private hospital admission was considered, Dr F based his discussion with the public hospital registrar, and his ultimate decision to keep Mrs A at home, on the incorrect information that Mrs A was being provided with 24-hour oversight and care by registered nurses.

Because of Mr B's failure to co-operate with other providers and share relevant information about Mrs A's level of care, such information was not able to be taken into account when decisions were made, and Mrs A's care was further compromised. In this regard, Mr B breached Right 4(5) of the Code.

Treatment

Once Mrs A's pressure sores had developed, in approximately August 2001, Mr B had a responsibility, in his role as "hands on" registered nurse, to initiate and/or advocate for further assessment and/or reassessment, to review Mrs A's care and/or the prevention strategies used to minimise the escalation of the problem, and to arrange for appropriate GP and wound specialist review, or hospitalisation.

There is evidence of Mrs A's developing pressure areas from approximately August 2001. Mr B did not bring the matter to the attention of Dr F, Mrs A's general practitioner, until 20 September 2001. My nursing advisor, Ms Eastgate, considered that Mrs A should have been

referred for surgical review of her pressure sores when they became necrotic. However, it was difficult for her to determine at exactly what point Mrs A should have been reviewed, because of the lack of ongoing documentation and assessment of the pressure areas.

Furthermore, Mr B did not care for Mrs A's wound appropriately or seek appropriate wound management advice. Ms Eastgate advised me that it was gravely concerning that Mr B did not complete a formal wound assessment and care plan at the outset. Mrs A's pressure areas required review by a wound care specialist nurse. Ms Phillips expressed concern as to the appropriateness of the wound care advice sought by Mr B, and it has emerged that Ms S was actually a community nurse with no special training in the management of wounds such as Mrs A's.

Both my nursing advisors expressed additional concern about the wound care products used. Ms Phillips advised that the hydrocolloid dressing that was used was "totally inappropriate for a heavily exudating wound". Ms E, while not recognising that the dressing was inappropriate, did ask Mr B "if he had had a review because that would seem to be appropriate". However, there is no evidence that Mr B arranged a review by an appropriate person.

If Mr B did not have sufficient knowledge to manage Mrs A's wound effectively, the onus was on him to seek advice from an appropriately qualified professional. He did not, and so breached Right 4(2) of the Code.

Pain management
As the registered nurse who was managing Mrs A's pressure areas, Mr B was responsible for ensuring that her pain levels were appropriately assessed and managed. With the exception of a short period of time when Ms E attended to Mrs A's wounds, Mr B was the sole registered nurse overseeing Mrs A's care and dressing her pressure areas from August 2001.

During Mrs A's final months, as her pressure areas developed, Mrs A should have been assessed and regularly reviewed for pain by Mr B and the other registered nurses involved in her care. Ms Phillips advised me that "pain management fell far short of what Mrs A could have expected when in the care of registered and enrolled nurses".

As well as pain from the pressure sores, which would have been painful when the dressings were changed, Mrs A would have had pain from the ulcers on her feet. Ms Phillips advised me that these ulcers had the appearance of "ischemic ulcers", which she described as "an extremely painful condition". The only two references to Mrs A's toes in the nursing agency notes are on 3 March 2001 in two separate entries by a nurse and a caregiver. There is very little documentation about the condition of Mrs A's toes, and it appears that they were not observed. It is therefore unknown over what period the ulcers developed. Mr B admitted that he was unaware of Mrs A's foot ulcers.

Both my advisors expressed concern that Mr B never completed a pain assessment to ascertain Mrs A's pain level. Only a low level of pain medication was administered to Mrs A

in her final months. In Ms Eastgate's view, Mrs A would consequently have endured a great deal of pain in the last weeks of her life.

Mr B's lack of assessment and inappropriate management of Mrs A's pain was inconsistent with professional nursing standards and amounted to a breach of Right 4(2).

Opinion: Breach – Ms C

Care planning and nursing practices
Ms C was the on-site senior nurse involved in Mrs A's care from the time of her discharge on 13 August 2000, until Ms C's employment with the nursing agency ceased effective from 19 January 2001. Her duties included writing and implementing care plans, supervising caregivers, and providing hands-on care. Ms C advised me that at the time her employment ceased on 19 January 2001, Mrs A had no pressure sores or broken areas of skin. I accept that there is no evidence to suggest that Mrs A's pressure areas had developed at this time, and accordingly Ms C had no role to play in the management of Mrs A's pressure areas.

However, as the initial registered nurse involved in Mrs A's day-to-day care, and the acknowledged team leader, Ms C had an important role to play in prevention of pressure areas. In particular, Ms C should have developed and documented an initial care plan to address the significant risk factors for pressure areas for Mrs A. Ms C acknowledged that her duties included writing and implementing care plans. However, as stated by my nursing advisor, Ms Eastgate, "There is no evidence of any assessment or care plan development during the period that [Ms C] cared for [Mrs A]."

In response to my provisional opinion, Ms C advised me that due to the unusual circumstances of this case, there was less necessity to formulate care plans, and arrange for appropriate nursing documentation, than would normally be the case. Ms C was working with only one client, and often worked fairly long hours, so would often have contact with staff covering the rest of the day. She was well able to discuss care requirements with all of the other staff involved in Mrs A's care.

Further comments were sought from my nursing advisor, Ms Phillips, about the need for formal documentation in a case such as this, where one-to-one care is being provided. Ms Phillips acknowledged that this is a difficult issue, but nevertheless stated that written documentation is a Nursing Council standard, and in this case it was poor. I agree with that advice.

Ms Phillips also advised that none of the registered nurses, including Ms C, were up- to-date with "pain management or pressure area care or the importance of nutrition to health". For example, Ms C advised that she would massage Mrs A's bottom as a pressure area prevention strategy. Ms Phillips advised me that this practice "has been discredited for a long time for contributing to tearing of susceptible tissues and breaking skin".

With regard to pressure area management, Ms C responded to my provisional opinion by advising me that as well as regular turning, she would clean Mrs A and "give her a gentle rub with cream". Ms C did not consider that gentle rubbing would break down tissues. Ms C also advised that while she was caring for her, Mrs A did not develop any pressure sores. Again, further comment was sought from Ms Phillips. Ms Phillips did not alter her opinion that the practice of rubbing was outdated, and not recommended for pressure area care management. Ms Phillips advised me that turning is the preferred management, and this is supported by numerous New Zealand and international studies.

Ms Eastgate advised that she would have expected Ms C to complete comprehensive assessments and care plans. Ms Phillips agreed that all registered nurses should be responsible for establishing and maintaining care plans.

In failing to establish and/or maintain a care plan or risk assessment for Mrs A, and in failing to keep up-to-date with current nursing practices, the care provided by Ms C was inconsistent with professional standards. Accordingly, Ms C breached Right 4(2) of the Code.

Opinion: No Breach – Ms C

Referrals
In my opinion, Mrs A would have benefited from a full review by health professionals including a physiotherapist, occupational therapist, and dietitian. I formed the provisional opinion that as the onsite senior nurse responsible for Mrs A's care, Ms C had a responsibility to arrange referrals to appropriate specialist services, particularly physiotherapy and dietary advice. In response to my provisional opinion, Ms C advised that Mrs A was being seen by other health professionals, including her geriatricians and Dr F. None of these people appear to have considered that she required referrals. Ms C further advised that she did discuss the fact that Mrs A was difficult with her food with her general practitioner, Dr F, who did not appear to consider that a referral to a dietitian was necessary.

I sought further advice from my nursing advisor, Ms Phillips, who accepted that determining who is responsible for referrals can be difficult. Ms Phillips advised that often each environment is different and sometimes it can be difficult to initiate referrals where they are not supported by other staff involved with the patient. Nevertheless, nurses are patient advocates and, where concerns are raised, consideration should be given to appropriate referral.

I accept that registered nurses do have a responsibility to arrange appropriate referrals. However, in this case, there was conflicting opinion about the necessity for referrals to be made. Ms C was not the manager with overall responsibility for Mrs A's care. While ideally, Ms C should have advocated more actively with others involved in Mrs A's care for

referrals to be made, her failure to do so did not amount to a breach of Right 4(5) of the Code.

Opinion: Breach – Ms E

Care planning, pressure area and pain management
Ms E was initially involved in Mrs A's care from the time of her discharge on 14 August 2000 until her resignation in April 2001, but this appears to have been in a peripheral role. Ms E advised me that her key role was in relation to weekend cover for Mr B, who had primary responsibility for Mrs A's care. Ms E's role was to advise caregivers as necessary during each alternate weekend when she provided cover. This was primarily by phone and in relation to dropping off supplies.

However, although the evidence suggests that Ms E's role was peripheral, my nursing advisors informed me that all of the registered nurses involved in Mrs A's care should have been responsible for establishing and maintaining care plans. Ms Phillips considered that Ms E's comment that she was not responsible for making clinical decisions indicated a misunderstanding of her role as a registered nurse. In response to my provisional opinion, Ms E indicated that in making this comment, she was trying to illustrate the different roles she and Mr B assumed in relation to Mrs A's care. She understands that nursing a patient involves making clinical decisions. In my view, formulating and maintaining care plans is a necessary component of this decision-making process.

Ms E also submitted that she had lesser responsibility for care planning because she was not "a regular employee" after April 2001, and had limited involvement before that time. Further comment was sought from Ms Phillips, who advised me that a registered nurse has a role as a patient advocate, and that responsibility is not abdicated because of infrequent involvement, particularly given that late in Mrs A's care, Ms E was one of the few registered nurses involved. I agree.

Ms Phillips also commented that although the information provided by Ms E indicated that she was aware of risk factors, for example nutrition, she "did nothing to instigate a formal process of risk assessment". I accept my nursing advice that when Ms E was present, she had the same responsibility for planning and referrals as other registered nurses.

Ms E became involved in Mrs A's care again in the months prior to her death, at a time when pressure sores were clearly a problem. Ms E recalled that she was shocked at the appearance of Mrs A's pressure sores when she saw her in October.

However, according to Ms Phillips, Ms E did not take appropriate steps to treat Mrs A's wound, or manage her pain during this time. These matters were Ms E's responsibility once she became involved in Mrs A's care again. Ms E appears to have been the one person who

recognised pressure sore risk factors and it was therefore incumbent on her to act on Mrs A's behalf by carrying out a risk assessment and addressing the modifiable risk factors.

In response to my provisional opinion, Ms E advised me that she could not initiate further risk management for the pressure areas, as this was already in place (ie, instructions to the staff regarding turning, and to use a hoist and belt to reduce friction and sheer). Further comment was sought from Ms Phillips, who responded that while this may be true, there was no documentation to support Ms E's contention that she had assessed the risks, and noted the management strategies in place. Ms E's responsibility was to ensure this was being done – she was aware that there were significant pressure areas and had a responsibility to ensure that everything possible was being done. Ms Phillips further commented that there was also absolutely no documentation by Ms E about the wound management or dressings that she undertook for Mrs A. This does not meet the Nursing Council standard for documentation.

I acknowledge Ms E's advice that she "was concerned about ongoing management of pain, exudates and odour", and that she discussed these concerns with Mr B the Monday after her four-day period of caring for Mrs A. In response to my provisional opinion, Ms E informed me that she did assess Mrs A's pain, and could find no verbal or physical indicators of pain. In my view, in the absence of any documentation in relation to Ms E's assessment of Mrs A's pain, the quality of any pain assessment undertaken by Ms E cannot be determined. Furthermore, Ms Eastgate advised me that in failing to chart regular pain relieving medication for Mrs A, and in failing to liaise with Dr F about appropriate prescriptions for pain relief, Ms E breached the Nursing Council Code of Conduct, Principles 2.2, 2.4, 4.3 and 4.6, which would incur disapproval from her peers.

In my view, in failing to establish and/or maintain a care plan or risk assessment for Mrs A, and to take appropriate steps to manage her wounds and her pain, Ms E did not comply with professional standards and breached Right 4(2) of the Code.

Opinion: No Breach – Ms E

Selection of appropriate wound dressing
Ms E and the other caregivers did not recognise that the hydrocolloid dressing used for Mrs A's necrotic pressure sore was totally inappropriate for a heavily exudating wound. Ms Phillips advised me that this dressing would result in the wound being "permanently wet", and indeed Ms E reported that this dressing was saturated after a 24-hour period.

Ms E recalled that when she arrived to provide cover during Mr B's absence, "the order for dressing equipment was there" and that she needed to change them. Although Ms E had not had experience in dealing with pressure sores like Mrs A's, she believed that the dressing being used was "designed to deal with a lot of exudate", and although the dressing was "pretty sodden by the end of 24 hours" she believed it was appropriate. Ms E advised me:

"While the product [Mr B] was using would seem to me to be suitable … I recall I asked him [on Monday morning] if he had had a review because that would seem clear to me to be prudent."

Ms E was not a wound specialist. She was not involved in deciding which type of dressing was appropriate for Mrs A's wound. To the best of her knowledge, the dressing that was already being used was appropriate. However, she did recognise the limitation of her expertise in this area, and accordingly advised Mr B that she "felt a review would be appropriate" when he returned. In my view these actions were reasonable in the circumstances. Accordingly, Ms E did not breach the Code in relation to this issue.

Opinion: Breach – Ms D

Care planning
I have been unable to establish the exact dates of Ms D's employment with the nursing agency. Ms D advised me that she initially worked on a couple of shifts with Mrs A when she was employed by another nursing agency. It appears likely that Ms D's employment commenced either in December 2000, or in February 2001, when her shifts started to become more regular. Ms D appears to have left the employment of the nursing agency on 20 June 2001.

All registered nurses should be responsible for establishing and/or maintaining care plans. There is no evidence that Ms D planned, updated and/or documented appropriate preventative measures during the time she cared for Mrs A.

Ms Eastgate commented that Ms D's use of sandbags was not best or recommended practice. (In response to my provisional opinion, Ms D advised me that the only aids available to her at the time were the sandbags. Although they were not best or recommended practice, she believed they were better than nothing.) The use of a "ring device" as a pressure area preventive measure was also inappropriate as it is now known that these devices can cause pressure areas.

In the circumstances, Ms D breached Right 4(2) of the Code by her inadequate care planning.

Co-operation with other providers to ensure safe and quality care
Ms D advised me that when the nursing staff were informed of the proposed cutbacks, she was concerned that Mrs A's care was going to be the responsibility of the caregivers and Mr B. Ms D stated that despite her concerns "we accepted this explanation without further ado. After all we are only employees!" She also advised me that she believed the care that Mrs A deserved was compromised. Mrs A was not an easy person to care for, and Ms D believed she needed two people caring for her all of the time. Yet there is no evidence that she expressed these concerns to Mr B or any of the other professionals involved in Mrs A's care at any stage.

I acknowledge that Mr B did not seek the opinions of the caregiving staff as to whether the proposed staffing reductions were appropriate. It would have made it considerably easier for staff members to express an opinion if he had. However, the need to co-operate with other providers to ensure quality, and especially a safe standard of care, was not Mr B's responsibility alone. If Ms D was not comfortable raising her concerns with Mr B, she could also have raised them with other professionals involved in Mrs A's care, such as her general practitioner, Dr F. All of the providers involved in Mrs A's care, including Mr B and other nursing staff, had a responsibility to co-operate with other providers to ensure quality and a safe standard of care. This is particularly so in the case of Mrs A, who was not able to speak for herself.

My nursing advisor, Ms Phillips, advised me that there is a professional expectation for registered nurses to raise any concerns they have about the adequacy of their patients' care.

I agree. In my opinion, Ms D breached Rights 4(2) and 4(5) of the Code in the above respects.

Opinion: Breach – Ms G

Reporting of concerns
Ms G cared for Mrs A on night shift, as an employee of the nursing agency between August 2000 and February 2001. This was a lengthy shift (either 12 or 14 hours) and Ms G advised that she worked alone after the assisting caregiver left at 11pm.

Ms G advised that when she was working alone with Mrs A, she was unable to mobilise her, or assist her with toileting, as two staff members were required to accomplish these tasks. She recalled that when the staff had been informed of proposed cutbacks, she "knew what was going to happen to [Mrs A]" (that her level of care would drop), yet did not express her concerns to anyone involved in Mrs A's care at that time or later, when the impact of the cutbacks on Mrs A became fully apparent.

In response to my provisional opinion, Ms G advised me that she was unaware that Mrs A had sufficient funds to afford a second nurse, and had she known that Dr O had expected that "a registered nurse [should have] been employed for at least part of every day", she would have raised the issue with other staff members. Nevertheless, Ms G was aware of the impact the staffing reductions had on Mrs A, and had concerns about the drop in her level of care. As noted by Ms Phillips, enrolled nurses are expected to raise any concerns about the adequacy of their patients' care.

In failing to act as an advocate for Mrs A and to report her concerns, Ms G did not comply with professional standards and breached Rights 4(2) and 4(5) of the Code.

Opinion: No breach – Dr F

Dr F became involved in Mrs A's care at the request of the public hospital staff, who contacted him seeking a general practitioner who could oversee Mrs A's care in the community. In this role Dr F had responsibility for the overall management of Mrs A's medical problems. My expert advisor, Dr Turnbull, commented that all aspects of Mrs A's care, including medical, social, mental and nursing aspects, were a partnership between Dr F, Mr J, all the nursing agency staff, and the public hospital geriatricians and haematologist, and "all had a role in the prevention of pressure sores".

With regard to prevention, Dr F advised me that Mrs A's pressure sores were first brought to his attention on 20 September 2001. Prior to this he had no knowledge of pressure sores being a problem, and advised me that he "would normally expect nursing staff to notify me if they were concerned about bedsores being an issue".

Dr F was reliant on the information about pressure areas given to him by Mr B. Dr F's records show that he maintained contact with staff at the nursing throughout Mrs A's time at home, and also visited her intermittently. It would not be reasonable to expect Dr F to undertake a complete physical examination at these visits, particularly when, to the best of his knowledge, Mrs A was receiving 24-hour nursing care. The onus was on the nursing staff to bring any matters of concern to Dr F's attention.

With regard to the treatment of Mrs A's pressure sores, Dr F advised me that when the problem was brought to his attention on 20 September, he was sufficiently concerned to discuss Mrs A's case at length with the surgical registrar at the public hospital. The option of hospital admission was considered, but Dr F advised that because of Mrs A's "dementing illness, access to 24 hour nursing care and reluctance to enter hospital it was decided to nurse her at home". Dr F prescribed antibiotics for Mrs A's septicaemia, and obtained advice about wound care management, which he conveyed to Mr B. After receiving telephone advice from Mr B that Mrs A was improving and the pressure areas were healing, Dr F subsequently viewed the pressure areas again on 25 October 2001, noting "no real improvement". On 30 October 2001, he discussed Mrs A's anaemia with the public hospital haematologist, and the possibility of a transfusion was considered. Dr F viewed the area again on 13 November 2001, at which time he brought the matter to the attention of Dr O. His remaining involvement consisted of liaison with the nursing agency by telephone.

In considering Dr F's actions in relation to the treatment of Mrs A's pressure areas, it is necessary to consider the information available to him at the time. Dr F was unaware of the nursing staff reductions that had occurred. To the best of Dr F's knowledge, Mrs A was receiving "excellent" 24-hour nursing care in her home, and his subsequent actions were based on that information. It was appropriate for Dr F to rely on the information about Mrs A's condition that was conveyed to him by Mr B.

In her further report on the actions of Dr F, Dr Turnbull commented that Dr F was an advocate and medical advisor to Mrs A, and worked as part of a team with her welfare guardian and nursing providers, with additional input from specialist providers. As stated by Dr Turnbull, "Good communication and networking is essential in such a situation."

However, in this case "[t]here were some serious deficiencies in the flow of information to [Dr F] from the nursing provider …".

I have noted Ms Eastgate's comments that Dr F should have referred Mrs A for hospital level care. However, her comments are based, in part, on the assumption that Dr F was aware that Mrs A was frequently in the care of a single caregiver. In fact, Dr F was not aware of this. I therefore do not accept this aspect of Ms Eastgate's advice, and I disagree with Ms Eastgate's view that the care provided by Dr F was inadequate.

I have also noted Dr O's comment that referral of Mrs A back to him at an earlier stage would have been desirable. Dr Turnbull stated her view that:

> "[r]eferral back to [Dr O] could have been made a week or so earlier so that appropriate palliative care measures could be instituted. However, this is looking retrospectively and [Dr F] believed that a high standard 24 hour nursing care was being provided with registered nursing input."

In my view, although it may have been desirable for Dr F to have followed up Mrs A more closely once he had viewed the pressure areas, this is more clearly evident with the benefit of hindsight. There is no evidence that Dr F's actions were contrary to the professional standards for a general practitioner, or that he failed to co-operate effectively with Mr B and the other health professionals involved in Mrs A's care. Effective communication is a two-way process and Dr F did not have access to accurate information relevant to Mrs A's needs. Accordingly, Dr F did not breach Rights 4(2) or 4(5) of the Code.

Other comments

Intervention after death
In response to the funeral directors' description of the post-mortem appearance of Mrs A's pressure areas, Mr B advised me:

> "Please be aware that [Mrs A's body] remained in her apartment after her death for in excess of 24 hours. In that time the ulcers were not cleaned or dressed. It is not surprising that their appearance to the staff at the funeral directors was as reported."

In light of Mr B's concerns about the accuracy of the reported severity of Mrs A's ulcers, an opinion was sought from a forensic pathologist as to the likelihood that there had been post-mortem changes to the photographed areas. While noting that the photographs were not of sufficient quality for a detailed comment to be made, the forensic pathologist concluded: "From the appearances seen, I do not believe the bed sores had changed significantly from what they would have been whilst Mrs A was still alive." A full copy of the pathologist's report is attached at Appendix A.

The public hospital's involvement
I have noted my advisor Ms Eastgate's views about the services provided to Mrs A from "Older Persons' Health" at the public hospital. However, in my view there is no evidence of an apparent breach of the Code in relation to the services provided by the public hospital to Mrs A. After a series of arrangements were put in place, Mrs A was discharged from the public hospital to the care of the nursing agency, who were to provide 24- hour nursing care to Mrs A in her home. Although Dr P and Dr O continued to visit Mrs A as an outpatient, the responsibility for Mrs A's ongoing care and referrals lay with the nursing agency after her hospital discharge. Dr P and Dr O were dependent on the nursing agency caring for Mrs A to convey relevant information related to Mrs A's ongoing care, and to seek assistance from them as necessary. This did not occur, and in my view there is insufficient evidence to suggest that follow-up from the public hospital was inadequate.

Actions taken

In response to my provisional opinion, Mr B, Ms D and Ms G provided apologies, which have been forwarded to Mrs A's executors.

Recommendations

I recommend that Mr B, Ms C, Ms E, Ms D and Ms G take the following actions:

- Review their practice in light of this report
- Undertake further training on professional and ethical issues, under the direction of the Nursing Council
- I recommend that Ms C and Ms E provide written apologies to the executors of Mrs A's estate, for their breaches of the Code. These apologies are to be provided to my Office and will be forwarded to the executors of Mrs A's estate.

Follow-up actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken against Mr B.

- A copy of this report will be sent to the Director-General of Health and the Nursing Council of New Zealand with a recommendation that the Council review the competence of Mr B, Ms C, Ms D and Ms E.

- A copy of this report, with details identifying the parties removed, will be sent to Age Concern, Elder Abuse and Neglect Services, the Disabled Person's Assembly (New Zealand) Incorporated, and Residential Care New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings issued proceedings before the Health Practitioners Disciplinary Tribunal and, at a hearing on 30 November 2005, a charge of professional misconduct was upheld. The Tribunal formed the view that it would not be appropriate for Mr B to resume nursing in a sole-care position when caring for elderly patients, and that Mr B must undergo a competency assessment, and satisfy the Nursing Council of New Zealand that he is safe and competent to practise nursing in any area of the profession he proposes to practise in. These orders will remain in force for three years from the date Mr B returns to practise as a nurse, should he do so.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A – Report from pathologist

"At the request of the Health & Disability Commissioner, I have reviewed photographs and documents as listed in an appendix to this letter.

- Complaint by [Mr H] (property guardian) forwarded by solicitors […] marked 'A' (1-14)
- Minutes of two meetings, email from [Mr H] and embalmer's report (15-21) and 28 photographs, marked 'B'
- Responses to complaint from [Mr B], director of [the nursing agency], marked 'C' (22-27)
- Copy of [the nursing agency] records marked 'D' (27-184)
- Copy of [Dr F's] medical records marked 'E' (185-230).

I shall deal with the three questions in turn.

Q1. Are there post-mortem changes to [Mrs A's] body? If so, please describe these changes and explain their relevance in relation to the condition/appearance of [Mrs A's] pressure sores/foot ulcers.

A. The quality of the photographs is not sufficient to allow a particular detailed comment to be made. There appears to be no significant decomposition, and tissue details appears relatively well preserved, so I believe it unlikely that decomposition changes have contributed to the appearances seen in the photographs.

Q2. What impact, if any, did the delay between [Mrs A's] death and her embalming have on the condition/appearance of pressure sores and foot ulcers?

A. I doubt that there would have been any significant deterioration in the appearance of these lesions as seen by the naked eye. Had microscopic examination been undertaken, then there may have been degenerative changes visible due to early decomposition, but these changes are not apparent in the photographs supplied.

Q3. Is it possible for pressure sores/foot ulcers to deteriorate further after death? If so, to what extent and are there environmental or other factors which would contribute to this?

A. Yes, it is possible for any injury to deteriorate after death, due to the onset of decomposition and sometimes the involvement of flies and animals such as rats and mice having access to the body. The photographs supplied do not show any evidence that either decomposition was advanced or that there had been any maggot infestation or animal bites involved in the injuries. From the appearance seen, I do not believe the bed sores had changed significantly from what they would have been whilst [Mrs A] was still alive.

I hope these comments are of assistance to you in resolving this case."

APPENDIX B

Summary of Hours Worked: Year 2000

File No: 02/08905

Grid	
	Registered Nurse
	Enrolled Nurse
	Caregiver
	Uncertain qualification
	Shifts > 10 hours
	Double shifts and/or shifts >10 hours in 24 hour period
*	Overall shifts greater than 20 hours in 24 hour period.

Date	Name	Qualification	Hours Worked	Total Hours Worked
14 August 2000	Mr B		0930-1530	6
	Ms C		1200-2100	9
	Ms M		1830-2300	5
	Caregiver		2100-0700	10
	Ms C		2300-0700	8
15 August 2000	Ms C		0645-2100	12.25
	Registered Nurse		0645-1830	11.25
	Caregiver		2100-0700	10
	Caregiver		2300-0700	8
	Ms M		1730-2300	5.5
16 August 2000	Registered Nurse		0645-2100	14.25
	Ms D		2100-0700	10
	Ms N		0715-1600	8.75
	Ms M		1530-2300	7.5
	Caregiver		2245-0700	8.25
17 August 2000	Registered Nurse		0645-1530	8.25
	Registered Nurse		1530-2300	7.5
	Registered Nurse		2245-0700	8.25
	Caregiver		0645-2300	17.25

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Caregiver	2300-0700	8
18 August 2000	Registered Nurse	0645-1530	8.25
	Ms C	1530-2300	8.5
	Registered Nurse	2245-0700	8.25
	Ms G	0645-1530	10.25
	Caregiver	1530-2300	8.5
	Caregiver	2300-0700	8
19 August 2000	Registered Nurse	0645-1900	14.25
	Ms D	1900-0700	12
	Caregiver	1645-1600	9.25
	Caregiver	1830-0700	12
20 August 2000	Registered Nurse	0645-1900	14.25
	Ms D	0645-1901	14.25
	Caregiver	0645-1800	13.25
	Caregiver	1900-0630	11.5
21 August 2000	Ms N	12.00-1.00	1
	Ms M	17.30-2300	5.5
22 August 2000	Ms M	1730-0700	13.5
	Ms N	12.15-1600	3.75
23 August 2000	Ms N	12.00-1600	4
25 August 2000	Ms G	2100-0700	10
26 August 2000	Ms G	2100-0700	10
27 August 2000	Ms G	2100-0700	10
28 August 2000	Ms G	2100-0700	10
	Ms C	0645-2100	14.25
29 August 2000	Ms C	0645-2100	14.25
30 August 2000	Ms C	0645-2100	14.25
31 August 2000	Caregiver	1900-0700	12
	Ms G	2100-0700	10
	Ms C	0645-2100	14.25
1 September 2000	Ms G	2100-0700	10
	Ms C	0645-2100	14.25
2 September 2000	Ms G	1900-0700	12

3 September 2000	Ms G	1900-0700	12
4 September 2000	Ms G	2100-0700	10
5/9/2000-10/9/2000	No hours available Timesheets missing.		
11 September 2000	Ms M	1430-1800	5.5
		0645-0800	
		0900-1300	
	Ms C	1500-1900	8.25
12 September 2000	Ms C	0645-2100	14.25
	Ms T	1800-2300	5
	Ms M	1230-1800	5.5
13 September 2000	Ms C	0645-1900	12.25
	Ms T	1800-2300	5
	Ms M	1200-1800	6
14 September 2000	Ms C	0645-2100	14.25
	Ms T	1100-1900	8
	Ms G	2100-0700	10
	Ms M	1230-2300	10.5
15 September 2002	Ms C	0645-2100	14.25
	Ms M	1430-1800	5.5
	Ms G	2100-0700	10
16 September 2000	Ms G	2300-0700	8
17 September 2000	Caregiver	2300-0700	8
	Ms G	1900-0700	12
18 September 2000	Ms C	0645-2100	14 1/4
	Ms G	2100-0700	10
	Ms M	1430-1800	5 1/2
	Ms T	1800-2300	5
19 September 2000	Ms C	0645-2100	14 1/4
	Ms M	1230-1800	5 1/2
	Ms T	1800-2300	5
20 September 2000	Ms C	0645-2100	14 1/4
	Ms M	1230-1800	5 1/2

	Ms T		0800-1800	9 1/2
21 September 2000	Ms C		0645-2100	14 1/4
	Ms G		2100-0700	10
	Caregiver		2300-0700	8
	Ms M		1230-1800	5 1/2
22 September 2000	Ms C		0645-2100	14 1/4
	Ms G		2100-0700	10
23 September 2000	Ms G		1900-0700	12
24 September 2000	Ms G		1900-0700	12
25 September 2000	Ms C		0645-2100	14 1/4
	Ms M		1400-1800	4
	Ms T		1800-1100	5
	Caregiver		2300-0700	8
	Ms G		2100-0700	10
	Ms C		0645-2100	14 1/4
26 September 2000	Ms T		1800-0700	13
	Ms M		12.30-6.00	5 1/2
	Ms C		0645-1900	12 1/4
27 September 2000	Ms T		1800-0700	13
	Ms M		12.30-6.00	5 1/2
	Ms C		0645-2100	14 1/4
28 September 2000	Caregiver		2300-0700	8
	Ms M		12.30-11.0	10 1/2
	Ms G		2100-0700	10
	Ms C		0645-2100	14 1/4
29 September 2000	Ms G		2100-0700	10
	Caregiver		1800-0700	13
30 September 2000	Ms G		1900-0700	12
	Caregiver		1400-0700	17
2 October 2000	Ms M		1400-1800	4
	Caregiver		0700-1400	7
	Caregiver		1800-0700	13
	Ms M		1400-1800	4

	Ms C	0645-2100	14.25
	Ms G	2100-0700	10
3 October 2000	Ms M	12.30-1800	5.5
	Caregiver	1900-0700	12
	Ms C	0645-1800	11.25
4 October 2000	Ms C	0645-2100	14.25
	Ms M	12.30-1800	5.5
	Ms T	1800-0700	13
5 October 2000	Ms C	0645-2100	14.25
	Ms M	12.30-2300	10.5
	Ms T	2300-0700	8
	Ms G	2100-0700	10
6 October 2000	Ms C	0645-1900	12.25
	Ms M	12.30-1800	5.5
	Ms G	1900-0700	12
7 October 2000	Ms G	1900-0700	12
	Caregiver		
8 October 2000	Caregiver	1800-0700	13
	Caregiver	0600-1800	12
9 October 2000	Caregiver	0700-1200	5
	Caregiver	1800-0700	13
	Ms T	0645-2100	14.25
10 October 2000	Caregiver	1800-0700	13
	Ms C	0645-1900	12.25
11 October 2000	Ms C	0645-1900	12.25
	Ms T	1800-2300	5
12 October 2000	Ms C	0645-1900	12.25
	Ms M	1700-2300	5
13 October 2000	Ms C	0645-1830	11.75
14 October 2000	Caregiver	0645-1831	12.75
15 October 2000	Caregiver	0700-1200	5
	Caregiver	1700-2300	6

16/10-2000-20/11/2000	No hours available Timesheets missing.			
20 November 2000	Ms C		0645-1500	8.25
	Ms G		1900-0700	12
	Caregiver		1700-2030	3.5
21 November 2000	Ms C		0645-1900	12.25
	Ms T		1700-2300	6
22 November 2000	Ms C		0645-1900	12.25
	Ms T		1700-2300	6
23 November 2000	Ms C		0645-1200	5.25
	Ms G		1900-0700	12
	Ms M		1700-2300	6
24 November 2000	Ms C		0645-1500	8.25
	No hrs recorded 1500-1900			
	Ms G		1900-0700	12
26 November 2000	Ms G		1900-0700	12
	No hrs recorded 1200-1700			
			0800-1200	4
16 December 2000	Caregiver		1700-2300	6
16/12-2000-25/12/2000	No hours available Timesheets missing.			
25 December 2000	Ms C		0645-1515	8.5
	Ms L		0800-1200	4
	Ms T		1500-2300	8
	Caregiver		1700-2300	6
	Ms G		2245-0700	8.25
26 December 2000	Ms C		0645-1515	8.5
	Ms L		0800-1200	4
	Ms L		1800-2300	8
	Caregiver		1700-2300	6
	Ms G		2245-0700	8.25
27 December 2000	Ms C		0645-1515	8.5

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms L	0800-1200	4
	Ms L	1500-2300	8
	Ms T	1700-2300	6
	Ms D	2245-0700	8.25
28 December 2000	Ms C	0645-1515	8.5
	Ms L	0800-1200	4
	Ms L	1500-2300	8
	Ms T	1700-2300	6
	Ms D	2245-0700	8.25
29 December 2000	Ms C	0645-1516	7.4
	Ms L	0800-1200	7.55
	Ms L	1500-2300	7.7
	Ms T	1700-2300	7.85
	Ms G	2245-0700	8
30 December 2000	Caregiver	0800-1200	4
	Ms D	0645-1500	8.25
	Caregiver	1500-2300	8
	Ms K	1700-2300	6
	Ms G	2245-0700	8.25
31 December 2000	Ms D	0645-1500	8.25
	Caregiver	0900-1200	4
	Caregiver	1500-2300	8
	Ms K	2100-0700	10

APPENDIX C

Summary of Hours Worked: Year 2001

File No: 02/08905

Grid

	Registered Nurse
	Enrolled Nurse
	Caregiver
	Shifts > 10 hours
	Double shifts and/or shifts >10 hours in 24 hour period

Date	Name	Qualification	Hours Worked	Total Hours Worked
1-8 Jan 2001	No hours available Timesheets missing.			
8 January 2001	Ms C		0645-1500	8.25
	Caregiver		0800-1200	4
	Caregiver		1700-2300	6
	Enrolled Nurse		1445-0700	16.25
9 January 2001	Ms C		0700-1515	8.25
	Caregiver		0800-1200	4
	Caregiver		1700-2300	6
	Ms M		1500-2300	8
	Ms D		2245-0700	8.25
10 January 2001	Ms C		0645-1515	8.25
	Ms K		0800-1200	4
	Ms K		1500-2300	8
	Ms T		1700-2300	6
	Ms D		2245-0700	8.25
11 January 2001	Ms C		0645-2300	8.25
	Caregiver		0800-	No finish time recorded
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms T		2300-0700	8
12 January 2001	Ms C		0645-1515	8.25

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms L		0800-1200	4
	Ms T		1700-2300	6
	Ms L		1445-2300	8.15
	Ms T		2300-0700	8
13 January 2001	Ms L		0645-1515	8.3
	Caregiver		0645-1516*	8.3
	Ms L		0645-1517	8.3
	Caregiver		0645-1518	8.3
	Enrolled Nurse		2300-0700*	8
14 January 2001	Enrolled Nurse		0700-1525*	8.25
	Ms K		0800-1200	4
	Ms K		1500-2300	8
	Ms G		1500-2301*	8
15 January 2001	Ms C		0645-1515	8.25
	Ms L		0800-1200	4
	Ms L		1500-2300	8
	Caregiver		1700-2300	6
	Ms G		2245-0700	8.25
16 January 2001	Ms C		0700-1515	8.25
	Caregiver		0800-1200	4
	Caregiver		1700-2300	6
	Ms M		1500-2300	8
	Ms G		2245-0700	8.25
17 January 2001	Ms C		0645-1515	8.25
	Ms K		0800-1200	4
	Ms T		1500-2300	6
	Ms G		1500-2300	8
	Ms G		2245-0700	8.25
18 January 2001	Ms C		0645-1515	8.25
	Ms K		0800-1200	4
	Ms M		1500-2300	8

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms T		1500-2300	6
	Ms M		2300-0700	8
19 January 2001	Ms C		0645-1515	8.25
	Ms K		1300-2300	10
	Ms T		1500-2430	7
	Ms G		2430-0700	7.5
20 January 2001	Ms K		0645-1515	8.5
	Caregiver		0800-1200	4
	Caregiver		1500-2300	8
	Ms G		1700-0700	14
21 January 2001	Ms L		0800-0900	1
	Ms T		0645-1500	8
	Ms K		0800-1200	4
	Ms K		1500-2300	8
	Ms G		1700-0700	14
22 January 2001	Ms L		0645-2300	16.25
	Ms K		0800-1200	4
	Caregiver		1700-2300	6
	Ms T		1700-2300	6
	Ms G		2245-0700	8.25
23 January 2001	Ms K		0645-1530	8.45
	Ms L		0930-1030	1
	Ms M		1500-2300	8
	Caregiver		1700-2300	6
	Ms G		2245-1100	12.25
24 January 2001	Ms K		0645-1730	10.5
	Ms T		1645-2300	6.15
	Ms G		1900-2400	5
	Ms G		2400-1200	12
25 January 2001	Ms K		0700-1530	8.5
	Ms M		1500-2300	8
26 January 2001	Ms M		2300-0700	8
	Ms T		1700-2300	6

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms L		0645-2300	16.25
	Ms K		0800-1200	4
	Ms T		1700-2300	6
	Ms G		2300-0700	8
27 January 2001	Ms G		0700-0700*	24
	Ms T		0800-1200	4
	Ms K		1500-2300	8
28 January 2001	Ms K		0700-2300	16
	Ms T		0800-1200	4
	Ms G		1700-0700	14
29 January 2001	Ms K		0800-1200	4
	Ms L		0645-1700	10.25
	Ms T		1700-2300	6
	Caregiver		1700-2300	6
	Ms G		2345-1100	12.25
30 January 2001	Ms K		0645-1530	8.75
	Ms M		1500-2300	8
	Caregiver		1700-2300	6
	Ms G		2245-0700	8.25
31 January 2001	Ms K		0645-1530	8.75
	Ms G		1300-1200	23
	Ms T		1700-2300	6
1 February 2001	Ms K		0645-1530	8.75
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms M		2300-0700	8
2 February 2001	Ms L		0645-2300	16.25
	Ms K		0800-1200	4
	Ms T		1700-2300	6
	Ms G		2245-0700	8.25
3 February 2001	Caregiver		0800-1200	4
	Ms L		0645-1300	6.25
	Caregiver		1700-2300	6

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms G		1300-1700	18
4 February 2001	Ms K		0800-1200	4
	Ms T		0645-1300	8.25
	Ms K		1500-2300	8
	Ms T		1700-0700	16
5 February 2001	Ms L		1700-0701	16
	Ms K		0800-1200	4
	Ms M		1700-2300	6
	Ms T		1700-2300	6
	Ms T		2300-0700	8
6 February 2001	Ms K		0645-1530	8
	Ms L		1800-1200	8.75
	Ms M		1500-2300	4
	Caregiver		1700-2300	8
	Ms T		2300-0700	6
7 February 2001	Caregiver		0800-1100	8
	Ms K		0645-1700	3
	Ms K		1500-2300	10.25
	Ms T		1500-2300	6
	Ms T		2300-0700	8
8 February 2001	Ms K		0645-1530	8.75
	Caregiver		0800-0900	1
	Ms M		1500-2300	8
	Ms M		2300-0700	8
	Ms T		1700-2300	6
9 February 2001	Ms L		0645-2300	16.25
	Ms K		0800-1200	4
	Ms T		1700-0700	14
10 February 2001	Ms L		0645-1500	8.25
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Caregiver		1700-2300	6
	Ms T		2300-0700	8

11 February 2001	Ms K		0645-2300	16.25
	Ms T		0800-1200	4
	Ms T		1500-0700	16
12 February 2001	Ms L		1500-0701	16
	Ms K		0800-1200	4
	Ms T		1700-2300	6
	Caregiver		1700-2300	6
	Ms T		2300-0700	8
13 February 2001	Ms K		0645-1700	10.25
	Caregiver		0830-0930	1
	Ms T		1700-2300-0700	14
	Caregiver		1700-2300	6
14 February 2001	Ms K		0645-2300	16
	Caregiver		0800-1100	3
	Ms T		1700-2300	6
	Ms D		2300-0700	8
15 February 2001	Ms K		0645-1530	8.75
	Caregiver		0800-0900	1
	Ms T		1700-2300	6
	Ms M		1500—2300-0700	16
16 February 2001	Ms L		0645-2300	16.25
	Ms K		0800-1200	4
	Ms T		1700-2300	6
	Ms T		2300-0700	8
17 February 2001	Ms L		0645-1515	8.25
	Caregiver		0800-1200	4
	Caregiver		1700-2300	6
	Ms T		1500-2300	8
	Ms T		2300-0700	8
18 February 2001	Ms K		0645-2300	16
	Ms T		0800-1200	4
	Ms T		1500-2300-0700	16
19 February 2001	Ms K		1500-2300-0701	16

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Caregiver		0800-0900	1
	Caregiver		1700-2300	6
	Ms T		1700-2300	6
	Ms T		2300-0700	8
20 February 2001	Ms L		0645-1500	8.25
	Ms K		0800-1200	4
	Ms M		1500-2300	8
	Nicola		1700-2300	6
	Ms D		2300-0700	8
21 February 2001	Ms K		0645-2300	16
	Caregiver		0800-1000	2
	Ms T		1500-2300	8
	Ms D		2300-0700	8
22 February 2001	Ms K		0645-1530	8.75
	Caregiver		0800-0900	1
	Ms M		1500-2300-0700	16
	Ms T		1700-2300	6
23 February 2001	Ms L		0645-2300	16.5
	Ms K		0800-1200	4
	Ms T		1500-0700	16
24 February 2001	Ms L		0645-1500	8.25
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms T		2300-0700	8
	Caregiver		1700-2300	6
25 February 2001	Ms K		0645-2300	16
	Ms M		0800-1200	4
	Ms T		1500-2300-0700	16
26 February 2001	Ms L		0645-1700	10
	Ms K		0800-1200	4
	Caregiver		1700-2300	6
	Ms T		1700-2300	14
	Ms L		0800-1200	4

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

27 February 2001	Ms K	0645-1530	8.75
	Ms M	1500-2300	8
	Caregiver	1700-2300	6
	Ms D	2300-0700	8
28 February 2001	Ms K	0645-2300	16
	Caregiver	0900-1000	1
	Ms T	1500-25300	8
	Ms D	2300-0700	8
1 March 2001	Ms K	0645-1530	8.75
	Ms L	0800-1200	4
	Ms T	1700-2300	6
	Ms M	1500-2300-0700	16
2 March 2001	Ms L	0645-2300	16
	Ms K	0800-1200	4
	Ms T	1500-2300	16
	Ms T	2300-0700	8
3 March 2001	Ms L	0645-2300	16.25
	Caregiver	0800-1200	4
	Ms T	1500-2300	8
	Ms T	2300-0700	8
4 March 2001	Ms K	0645-2300	16
	Ms M	0800-1200	4
	Ms T	1500-2300-0700	16
5 March 2001	Ms L	0645-1700	10.25
	Ms K	0800-1200	4
	Caregiver	1700-2300	6
	Ms T	1700-2300-0700	14
6 March 2001	Ms K	0645-1530	8.75
	Caregiver	0800-0900	1
	Caregiver	1200-1400	2
	Caregiver	1700-2300	6
	Ms M	1500-2300	8
	Ms D	2245-0645	8

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7 March 2001	Ms K	0645-2300	16
	Caregiver	0800-1000	1
	Ms T	1500-2300	8
	Ms D	2245-0645	8
8 March 2001	Ms K	0645-1530	8.75
	Caregiver	0800-0900	1
	Ms M	1500-2300-0700	16
	Ms T	1700-2300	6
9 March 2001	Ms K	0645-1530	8.75
	Ms D	0800-1200	4
	Ms L	1700-2300	6
	Ms T	1500-2300	8
	Ms T	2300-0645	8
10 March 2001	Ms L	0645-1515	8.5
	Ms T	1500-2300-0700	16
	Caregiver	0800-1200	4
	Caregiver	1700-2300	6
11 March 2001	Ms K	0645-2300	16
	Ms M	0800-1100	3
	Ms T	1500-2300-0700	16
12 March 2001	Ms L	0645-1530	8.75
	Ms K	0800-1200	4
	Ms T	1500-2300	8
	Caregiver	1700-2300	6
	Ms T	2300-0700	8
13 March 2001	Ms K	0645-1530	8.75
	Caregiver	0800-0900	1
	Ms M	1500-2300	8
	Caregiver	1700-2300	6
	Ms D	2245-0645	8
14 March 2001	Ms K	0645-2300	16
	Caregiver	0800-1000	2
	Ms T	1500-2300	8

	Ms T		2300-0700	8
15 March 2001	Ms K		0645-1530	8.75
	Caregiver		0800-0900	1
	Ms T		1700-2300	6
	Ms M		1500-2300	8
	Ms M		2300-0700	8
16 March 2001	Ms K		0645-1530	8.75
	Ms D		0800-1200	4
	Ms T		1500-2300	8
	Ms L		1700-2300	6
	Ms T		2300-0700	8
17 March 2001	Ms T		0700-1500	8.75
	Ms T		1500-2300	8
	Caregiver		0800-1200	4
	Ms T		2300-0700	8
	Caregiver		1700-2300	6
18 March 2001	Ms K		0645-2300	16
	Ms M		0800-1200	4
	Ms T		1500-2300	8
	Ms L		2245-0700	8.25
19 March 2001	Ms L		0645-1715	9.5
	Ms K		0800-1230	4.5
	Ms T		1515-2300	8
	Ms T		2300-0700	8
	Caregiver		1700-2300	6
20 March 2001	Ms K		0645-1530	8.75
	Caregiver		0800-0900	1
	Ms M		1500-2330	8.5
	Caregiver		1700-2300	6
	Ms D		2330-0740	8
21 March 2001	Ms K		0645-2300	16
	Caregiver		0800-1000	2
	Ms T		1500-2300	8

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms D	2245-0700	8
22 March 2001	Ms K	0645-1530	8.75
	Caregiver	0800-0900	1
	Ms T	1700-2300	6
	Ms M	1500-2300	8
	Ms M	2300-0800	9
23 March 2001	Ms K	0645-1530	8.75
	Ms T	1500-2300-0700	16
	Ms L	1700-2300	6
24 March 2001	Ms L	0645-1500	8.25
	Ms T	0800-1200	4
	Ms T	1500-2300	8
	Ms K	1700-2300	6
25 March 2001	Ms K	0645-2300	16
	Ms M	0800-1200	4
	Ms T	1500-2300	16
26 March 2001	Caregiver	0800-1200	4
	Ms K	0800-1400	6
	Ms T	1500-2300-0700	16
	Caregiver	1700-2300	6
	Ms L	0645-1530	8.75
27 March 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms M	1500-2300	8
	Caregiver	1700-2300	6
	Ms D	2300-0700	8
28 March 2001	Ms K	0645-2300	16
	Caregiver	0800-1200	4
	Ms T	1500-2300	8
	Ms D	2300-0700	8
29 March 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms M	1500-2300	8

	Ms M		2300-0700	8
	Ms T		1700-2300	6
30 March 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1700-2300	6
	Ms M		1500-2300	8
	Ms T		2300-0700	8
31 March 2001	Ms L		0645-1500	8.25
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Caregiver		1700-2300	6
1 April 2001	Ms T		0700-1500-0800-1200	8
	Ms M		0800-1200	4
	Ms T		1500-2300	16
	Ms K		1500-2300	8
2 April 2001	Ms L		0645-1500	8.25
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms T		2300-0700	8
	Caregiver		0645-1530	6
3 April 2001	Ms K		0800-1200	8.75
	Caregiver		1500-2300	4
	Ms M		1700-2300	8
	Ms T		2245-0645	6
	Ms D		0645-2300	8
4 April 2001	Ms K		0800-1200	16
	Caregiver		1500-2300	4
	Ms T		2245-0645	8.5
	Ms D		0645-1530	8
5 April 2001	Ms K		0800-1200	8.75
	Ms D		1500-2300	4
	Caregiver		1700-2300	8
	Ms T		2300-0700	6

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms M	0645-1530	6
	Ms T	1500-2300	8
6 April 2001	Ms K	0645-1530	8.75
	Ms T	0800-1200	4
	Ms L	1700-0700	14
	Ms T	1500-2300	8
7 April 2001	Ms L	0645-1530	8.75
	Caregiver	0800-1200	4
	Caregiver	1700-2300	6
	Ms T	1500-2300-0700	16
8 April 2001	Ms K	0645-2300	16
	Ms T	0800-1200	4
	Ms T	1500-2300	8
	Ms T	2300-0700	8
9 April 2001	Ms L	0645-1530	8.75
	Ms T	0645-1200	5.25
	Caregiver	1700-2300	6
	Ms T	1500-2300-0700	16
10 April 2001	Ms K	0645-1530	8.75
	Ms T	1800-1200	4
	Ms M	1500-2300	8
	Nicola	1700-2300	6
	Ms D	2345-0745	8
11 April 2001	Ms K	0645-2300	16
	Ms T	0800-1200	4
	Ms T	1500-2300	9
	Ms D	2245-0645	8
12 April 2001	Ms K	0645-1530	8.75
	Ms T	0800-1200	4
	Ms M	1500-2300	8
	Ms T	1700-2300	6
	Ms M	2300-0700	8
13 April 2001	Ms K	0645-2300	16

	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
14 April 2001	Ms T		0645-1530*	8.75
	Caregiver		0800-1200	4
	Ms T		1530-2300-0700*	16
	Caregiver		1700-2300	6
15 April 2001	Ms K		0645-2300	16
	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
16 April 2001	Ms K		0800-1200	4
	Ms T		0645-2300*	16.75
	Caregiver		1700-2300	6
	Ms T		2300-0700*	8
17 April 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Caregiver		1700-2300	6
	Ms M		2300-0700	8
18 April 2001	Ms K		0645-2300	16
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms D		2245-0645	8
19 April 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-0700	14
20 April 2001	Ms K		0645-1500	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8.5
	Nele		1530-2300	8
	Ms T		2300-0700	8
21 April 2001	Ms T		0645-1530*	8.75
	Caregiver		0800-1200	4

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms T		1500-2300*	16
	Caregiver		1700-2300	6
22 April 2001	Ms K		0645-2300	16
	Ms T		0800-1200	4
	Ms T		1500-2300-0700	16
23 April 2001	Ms T		0645-1530*	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700*	16
	Caregiver		1700-2300	6
24 April 2001	Ms K		0645-1530	8.75
	Caregiver		8.00-1200	4
	Ms M		1500-2300	8
	Caregiver		1700-2300	6
	Ms T		2300-0700	8
25 April 2001	Ms K		0645-2300	16
	Caregiver		8.00-1200	4
	Ms T		1500-2300	8
	Ms D		2245-0645	8
26 April 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms M		2300-0700	8
27 April 2001	Caregiver		0800-+1200	4
	Ms K		0645-1530	8.75
	Ms T		1500-2300	8
	Ms L		1700-2300	6
	Ms L		2300-0700	8
28 April 2001	Ms L		0700-1230	5.5
	Caregiver		0800-1200	4
	Ms T		1230-2300	10.5
	Ms T		2300-0700	8
	Caregiver		1700-2300	6

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

29 April 2001	Ms K		0645-2300	16
	Ms T		0800-1200	4
	Ms T		1500-2300	16
30 April 2001	Caregiver		0800-1200	4
	Ms L		0645-1715	10.5
	Ms T		1330-2300	9.5
	Caregiver		1700-2300	6
	Ms T		2300-0700	8
1 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Caregiver		1700-2300	6
	Ms M		1500-2300	8
	Ms T		2300-0700	8
2 May 2001	Ms K		0645-2300	16
	Caregiver		0800-1200	4
	Ms T		1500-2300	9
	Ms D		2245-0645	8
3 May 2001	Nele		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms M		2300-0700	8
4 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms L		1700-2300	6
	Ms T		2300-0700	8
5 May 2001	Ms L		0645-1530	8.75
	Caregiver		0800-1200	4
	Caregiver		1700-2300	6
	Ms T		1500-2300	8
	Ms T		2300-0700	8
6 May 2001	Ms K		0645-2300	16

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
7 May 2001	Ms L		0645-1700	10.25
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Caregiver		1700-2300	6
8 May 2001	Ms K		0645-1530	8
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14
9 May 2001	Ms K		0645-2300	16
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms D		2245-0645	8
10 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6
	Ms M		1500-2300	8
	Ms M		2300-0700	8
11 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Ms L		1700-2300	6
12 May 2001	Ms L		0745-2330	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Caregiver		1700-2300	6
13 May 2001	Ms K		0645-2300	16
	Ms T		0800-1200*	4
	Ms T		1500-2300*	16
14 May 2001	Caregiver		0800-1200	4
	Ms T		1530-2300	8
	Ms T		2245-0700	8

	Ms L		1700-2300	16.5
15 May 2001	Ms K		0645-1530	8.75
	Ms T		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-0700	14
16 May 2001	Ms K		0645-2300	16
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms D		2245-0645	8
17 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6
	Ms M		1500-2300	8
	Ms M		2300-0700	8
18 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Ms L		1700-2300	8.5
19 May 2001	Ms L		0645-1230	5.75
	Caregiver		0800-2300	15
	Ms K		1530-2300	8
	Ms K		2245-0700	8
20 May 2001	Ms K		0645-2300	16
	Ms T		0800-1200	4
	Ms T		1500-2300-0700	16
21 May 2001	Caregiver		0800-1200	4
	Ms L		0645-2300	16.25
	Ms T		1500-2300	8
	Ms T		2300-0700	8
22 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

23 May 2001	Ms K		0645-2300	16
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms K		2245-0700	8
24 May 2001	Caregiver		0800-1200	4
	Ms K		0645-2300	8.75
	Ms T		1700-2300	6
	Ms M		1500-2300-0700	16
25 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Ms L		1700-2300	6
26 May 2001	Ms L		0645-1500	8.25
	Caregiver		0800-1200	4
	Ms T		1200-2300-0700	19
	Caregiver		1700-2300	6
27 May 2001	Ms K		0645-2300	16
	Ms T		0800-1200	4
	Ms T		1500-2300-0700	16
28 May 2001	Ms L		0645-2300	16.75
	Ms T		0800-1200*	4
	Ms T		1500-2300-0900*	16
29 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14
30 May 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	9
	Ms D		2245-0745	8
31 May 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6

	Ms M		1500-2300-0700	16
1 June 2001	Caregiver		0800-1200	4
	Ms K		0645-1500	8.75
	Ms L		1700-2300	6
	Ms T		1500-2300-0700	16
2 June 2001	Ms L		0645-1500	8.25
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Caregiver		1700-2300	6
3 June 2001	Ms K		0645-2300	16
	Ms T		0800-1200*	4
	Ms T		1500-2300*	16
4 June 2001	Ms L		0645-2300	16.25
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
5 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-0700	14
6 June 2001	Caregiver		0800-1200	4
	Ms T		0645-1530	8.75
	Ms K		1545-2300	8
	Ms T		1500-2300	8
	Ms D		2245-0645	8
7 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6
	Ms M		1500-2300-0700	16
8 June 2001	Caregiver		0800-1200	4
	Ms K		0645-1530	8.75
	Ms T		1500-2300-0700	16
	Ms L		1700-2300	6
9 June 2001	Ms L		0645-2300	8.25

	Ms T		0800-1200*	4
	Ms K		1700-2300.	6
	Ms		1500-2300-0700*	16
10 June 2001	Ms K		0645-2300	16
	Ms T		0800-1200	4
	Ms T		1500-2300	16
11 June 2001	Ms L		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		0900-1000	1(Shopping)
	Ms T		1500-2300-0700	16
12 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300-0700	14
	Ms M		1500-2300	8
13 June 2001	Caregiver		0800-1200	4
	Nele		06454-2300	16.75
	Ms T		1500-2300	8
	Ms D		2245-0645	8
14 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms M		2300-0700	8
15 June 2001	Ms K		0645-1530	8.75
	Caregiver		0/00-1200	4
	Ms T		1500-2300-0700	16
	Ms L		1700-2300	6
16 June 2001	Ms L		0645-1530	8.75
	Ms T		0800-1200*	4
	Ms K		1700-2300	6
	Ms T		1500-2300-0700*	16
17 June 2001	Ms K		0645-1500-2300	16.75
	Ms T		0800-1200*	4

	Ms T		1500-2300-0700*	16
18 June 2001	Ms L		0645-1200	5.75
	Caregiver		0800-1200	4
	Ms T		1200-2300	11
	Ms T		2300-0700	8
19 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms L		1500-2300	9
	Ms T		1500-2300-0700	16
20 June 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms D		2300-0700	4
21 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms L		1700-2300	6
22 June 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1530-2300-0700	6
	Ms K		1700-2300	6
23 June 2001	Ms K		0800-1200	4
	Ms T		0645-1530*	8.75
	Ms K		1700-2300	6
	Ms T		1500-2300-0700*	16
24 June 2001	Ms T		0800-1200*	4
	Ms K		0645-2300	16.75
	Ms T		1500-2300-0700*	16
25 June 2001	Caregiver		0800-1200	4
	Ms L		0645-2300	16.75
	Ms T		1500-0700	16.5
26 June 2001	Caregiver		0800-1200	4
	Ms K		0645-2300	16.75

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms T		1700-2300-0700	14
27 June 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms T		2300-0700	8
28 June 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
29 June 2001	Ms K		0645-2300	14.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700*	16
30 June 2001	Ms T		0645-1500*	8.75
	Ms K		0/00-1200-1700-2300	10
	Ms T		1500-2300-0700*	16
1 July 2001	Ms K		0645-2300	16.75
	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
2-8 July 2001	No hours available Timesheets missing.			
9 July 2001	Caregiver		0800-1200	4
	Ms L		0645-2300	16.25
	Ms T		1500-2300-0700	16
10 July 2001	Ms K		06545-1530-1700	10.25
	Caregiver		0800-1200	4
	Caregiver		1630-2300	6.5
	Ms T		1700-2300-0700	14
11 July 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms L		1700-2300	6
	Caregiver		2245-0700	8
12 July 2001	Ms K		0645-1530	6
	Caregiver		0800-1200	8.75
	Ms M		1500-2300	8

	Ms M		2300-0700	8
	Ms L		1700-2300	8
13 July 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms L		1500-2300	8
	Ms T		1500-2300-0700	16
14 July 2001	Ms L		0645-1530	8.25
	Ms T		0645-1200*	5.25
	Ms K		1700-2300	6
	Ms T		1700-2300-0700*	18
15 July 2001	Ms K		0645-2300	16.75
	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
16 July 2001	Ms K		0645-1530-1700-2300	16.25
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
17 July 2001	Ms K		0645-1530	8.75
	Caregiver		0/00-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14
18 July 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Caregiver		2300-0700	8
19 July 2001	Ms K		0645-1530	8.75
	Caregiver		0/00-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms M		2300-0700	8
20 July 2001	Caregiver		0800-1200	4
	Ms L		0645-2300	16.25
	Ms T		1700-2300	6
	Ms T		2300-0800	9

21 July 2001	Ms L		0645-2300	16.25
	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
22 July 2001	Ms K		0645-2300	16.75
	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16
23 July 2001	Caregiver		0800-1200	4
	Ms K		0645-1530-2300	16.75
	Ms T		1500-2300-0700	16
24 July 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14
25 July 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Caregiver		2300-0700	8
26 July 2001	Ms K		06454-1530	8.75
	Caregiver		0800-120	4
	Ms M		1500-2300	8
	Ms T		1700-2300	6
	Ms M		2300-0700	8
27 July 2001	Caregiver		0800-1200	4
	Ms L		0645-1500	8.25
	Ms L		1500-2300	8
	Ms T		1500-2300-0700	16
28 July 2001	Ms L		0645-1500	8.25
	Ms T		0800-1200	4
	Ms L		1500-2300	8
	Ms T		1500-2300-0700	16
29 July 2001	Ms K		1500-2300-0701	16
	Ms T		0800-1200*	4
	Ms T		1500-2300-0700*	16

30 July 2001	Ms K	1500-2300-0700	16.75
	Caregiver	0800-1200	4
	Ms T	1500-2300-0700	16
31 July 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms M	1500-2300	8
	Ms T	1700-2300	14
1 August 2001	Ms K	0645-2300	16.75
	Ms T	0800-1200	4
	Ms T	1500-2300	8
	Caregiver	2300-0700	8
2 August 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms M	1500-2300	8
	Ms T	1700-2300	6
	Ms M	2300-0700	8
3 August 2001	Ms L	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms L	1500-2300	8
	Ms T	1700-2300	6
	Ms T	2300-0700	8
4 August 2001	Ms T	0645-2300*	8.75
	Ms M	0800-1200	4
	Ms T	1500-2300-0700*	16
	Ms K	1700-2300	6
5 August 2001	Ms K	0645-2300*	16.75
	Ms T	0800-1200	4
	Ms T	1500-2300	16
	Ms L	2300-0700	6
6 August 2001	Caregiver	0800-1200	8.75
	Ms T	0645-1530	4
	Ms K	1700-2300	8
	Ms T	1530-2300-0700	16

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7 August 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	8
	Ms M	1500-2300	8
	Ms T	1700-2300	6
	Caregiver	2300-0700	8
8 August 2001	Ms T	Lieu Day	8
	Ms K	0645-2300	16.75
	Caregiver	0800-1200	4
	Caregiver	1300-1400	1
	Ms M	1700-2300	6
	Caregiver	2300-0700	8
9 August 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms K	1700-2300	6
	Ms M	1500-2300	8
	Ms M	2300-0700	8
10 August 2001	Ms L	0645-1500	8.75
	Caregiver	0800-1200	4
	Ms T	1700-2300	6
	Ms L	1500-2300	8
	Ms T	2300-0800	9
11 August 2001	Ms L	0645-1500	8.75
	Ms T	0800-1200	4
	Ms T	1700-2300	6
	Ms L	1500-2300	8
	Ms T	2300-0700	8
12 August 2001	Ms K	0645-2300	16.75
	Ms T	0800-1300	5
	Ms T	1500-2300-0700	16
13 August 2001	Ms K	1500-2300-0701	14.75
	Ms T	0800-1200*	4
	Ms T	1500-2300-0700*	16
14 August 2001	Ms K	0645-1530	8.75

	Ms T		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14
15 August 2001	Ms K		1700-2300-0701	14.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Caregiver		2300-0700	8
16 August 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6
	Ms M		1500-2300	8
	Ms M		2300-0700	8
17 August 2001	Caregiver		0800-1200	4
	Ms L		06454-1500	8.75
	Ms L		1500-2300	8
	Ms T		1700-2300	6
	Ms T		2300-0700	8
18 August 2001	Ms L		0645-2300	16.75
	Ms T		0800-1200	4
	Ms T		1500-2300-0700	16
19 August 2001	Ms K		0645-2300	16.75
	Ms T		0800-1200*	4
	Ms T		1400-2300-0700*	18
20 August 2001	Ms K		0645-2300	14.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
21 August 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-0700	14
22 August 2001	Ms K		0645-2300	14.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Caregiver		2300-0700	8
23 August 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6
	Ms M		1500-2300	8
	Ms M		2300-0700	8
24 August 2001	Ms L		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
	Ms L		1700-2300	6
25 August 2001	Caregiver		0800-1200	4
	Ms T		0645-2300	16.75
	Ms L		1700-0700	16
26 August 2001	Ms K		0645-2300	16.75
	Ms T		0800-1200*	4
	Ms T		1400-2300-0700*	17
27 August 2001	Ms K		0645-2300	17
	Caregiver		0800-1200	4
	Ms T		1500-2300-0700	16
28 August 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-2300-0700	14
29 August 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Caregiver		2300-0700	8
	Ms L		1500-2300	8
30 August 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms L		1700-2300	6
	Ms M		1500-0700	16
31 August 2001	Ms L		0645-2300	16.75
	Caregiver		0800-1200	4

	Ms K	1700-2300	6
	Ms L	2300-0700*	8
1 September 2001	Ms L	0645-2300*	16.75
	Caregiver	0800-2300	4
	Ms K	1700-2300	6
	Caregiver	2300-0700	8
2 September 2001	Ms K	0645-2300	16.75
	Caregiver	0800-1200	4
	Caregiver	1700-0700	14
3 September 2001	Ms K	0645-2300	16.75
	Caregiver	0800-1200	4
	Ms T	1500-0700	16
4 September 2001	Ms K	0645-1520	8.75
	Caregiver	0800-1200	4
	Ms M	1500-2300	8
	Ms T	1700-0700	14
5 September 2001	Ms K	0645-2300	16.75
	Ms T	0800-1200	4
	Ms T	1500-2300	8
	Caregiver	2300-0700	8
6 September 2001	Ms K	0645-1530	8.75
	Caregiver	0800-1200	4
	Ms M	1500-2300	8
	Ms T	1700-2300	6
	Ms M	2300-0700	8
7 September 2001	Ms L	0645-2300	16.75
	Caregiver	0800-1200	4
	Ms T	1700-0700	14
8 September 2001	Ms L	0645-2300	16.75
	Ms T	0800-1200	4
	Ms T	1700-2300-0700	14
9 September 2001	Ms K	0645-2302	16.75
	Ms T	0800-1200*	4

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms T		1500-0700*	16
10 September 2001	Ms K		0645-2300	15.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Ms T		2300-0700	8
11 September 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms M		1500-2300	8
	Ms T		1700-0700	14
12 September 2001	Ms K		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-2300	8
	Caregiver		2300-0700	8
13 September 2001	Ms K		0645-1530	8.75
	Caregiver		0800-1200	4
	Ms T		1700-2300	6
	Ms M		1500-2300	8
	Ms M		2300-0700	8
14 September 2001	Ms L		0645-2300	16.75
	Caregiver		0800-1200	4
	Ms T		1500-0700	16
15 September 2001	Ms L		0645-2300	16.75
	Ms T		0800-1200	4
	Ms T		1500-0700	16
16 September 2001	Ms K		0645-2300	16.75
	Ms T		0800-1200	4
	Ms T		1700-2300	6
	Ms T		2300-0700	8
17 September 2001	Ms K		0645-0530	8.75
	Caregiver		0900-1200	3
	Ms T		1500-0700	16
	Ms K		1800-2200	5
18 September 2001	Ms K		0645-1530	8.75

	Caregiver		0900-1200	3
	Ms M		1500-2300	8
	Ms T		0800-0700	13
19 September 2001	Ms K		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms T		1500-2300	8
	Ms K		1800-2300	5
	Caregiver		2300-0700	8
20 September 2001	Ms K		0645-0530	8.75
	Caregiver		0800-1100	3
	Ms M		1500-2300	8
	Ms T		1800-2300	5
	Ms M		2300-0700	8
	Ms T		2300-0900	10
21 September 2001	Ms L		0645-2300	16.25
	Caregiver		0900-1500	6
	Ms T		1300-2300	8
	Ms T		2300-0700	8
	Caregiver		2300-0700	8
22 September 2001	Ms L		0645-1700	10.25
	Ms T		0645-2300*	16.24
	Caregiver		1700-2300	6
	Ms T		2300-0700*	8
	Caregiver		2300-0700	8
23 September 2001	Ms K		0645-2300	16.75
	Ms T		0645-2300	16.75
	Ms T		2300-0700	8
	Ms M		2300-0700	8
1 October 2001	Ms K		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms T		1500-0700	16
	Ms K		1800-2300	5
2 October 2001	Ms K		0645-1530	8.75

	Caregiver		0900-1230	3.5
	Ms T		1800-0700	13
	Ms M		1500-2300	8
3 October 2001	Ms K		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms T		1500-2300	8
	Ms K		1800-2300	5
	Ms M		2300-0700	8
4 October 2001	Ms K		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms M		1500-2300	3
	Ms M		2300-0700	8
	Ms T		1800-2300	5
5 October 2001	Caregiver		0900-1200	3
	Ms L		0645-2300	16.25
	Ms T		1800-0700	13
6 October 2001	Ms L		0645-2300	16.25
	Ms T		0800-1200	4
	Ms T		1800-0700	13
7 October 2001	Ms K		0645-2300	16.75
	Ms T		0800-1100	3
	Ms T		1800-0700	13
8 October 2001	Ms K		0645-2300	13.75
	Caregiver		0900-1200	3
	Ms T		1500-0700	16
9 October 2001	Ms K		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms T		1300-1500	2
	Ms M		1500-2300	8
	Ms T		1800-0700	13
10 October 2001	Ms K		0645-2300	14.25
	Caregiver		0900-1200	3
	Ms T		1500-0700	16

11 October 2001	Ms K	0645-1530	8.75
	Caregiver	0900-1200	3
	Ms M	1500-2300	8
	Ms T	1500-2300	5
	Ms M	2300-0700	8
12 October 2001	Caregiver	0900-1200	3
	Ms L	0645-0645*	24
13 October 2001	Caregiver	0900-1200	3
	Ms L	0645-2300*	16.75
	Ms K	1900-0700*	12
14 October 2001	Ms K	0645-2303*	16.75
	Caregiver	0900-1200	3
	Ms L	1900-2000	1
	Ms M	2300-0700	8
15 October 2001	Ms K	0645-2300	16.75
	Caregiver	0900-1200	3
	Caregiver	1800-2300	5
	Ms K	2300-0700	8
16 October 2001	Ms K	0700-1530	8.25
	Caregiver	0900-1200	3
	Caregiver	1800-2300	5
	Ms M	1500-2300	8
	Ms K	2300-0700	8
17 October 2001	Ms K	0700-2300--0700	24.75
	Caregiver	0900-1200	3
	Caregiver	1800-2300	5
18 October 2001	Ms K	0645-1530	8.75
	Caregiver	0900-1200	3
	Ms M	1500-2300	8
	Caregiver	1800-2300	5
	Ms M	2300-0700	8
19 October 2001	Ms L	0645-0700	24.5
	Ms K	0900-1200	3

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	Ms K		1800-2300	5
20 October 2001	Caregiver		0900-1200	3
	Ms L		0645-2300	16.25
	Caregiver		1800-2300	5
	Caregiver		2300-0700	8
21 October 2001	Caregiver		0800-1100	3
	Ms K		0645-0700	24.75
	Caregiver		1700-1900	2
22 October 2001	Ms K		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms T		1515-2300	8
	Ms K		1800-2300	5
	Ms T		1800-2301	5
23 October 2001	Caregiver		0900-1200	3
	Ms T		0645-1530*	8.75
	Ms M		1530-2300	8
	Ms T		1800-2300-0700*	13
24 October 2001	Ms T		0645-1530*	8.75
	Caregiver		0900-1200	3
	Ms T		1530-2300*	8
	Ms T		1800-2300*	5
	Ms M		2300-0700	13
25 October 2001	Ms T		0645-1530	8.75
	Caregiver		0900-1200	3
	Ms T		1800-2300	5
	Ms M		1500-2300-0700	16
26 October 2001	Caregiver		0900-1200	3
	Ms T		1800-2300-0700	13
	Caregiver		1600-2300	7
	Ms L		0645-1600	9.25
27 October 2001	Ms T		0645-1530	8.75
	Ms M		0900-1200	3
	Ms L		1530-2300	8

	Ms T		1800-2300-0700	13
28 October 2001	Ms K		0645-2300	16.75
	Ms T		0800-1100	3
	Ms T		1800-2300-0700	13
28 Oct - 19 Nov 2001	No hours available Timesheets missing.			

Note:

There are 8 partially complete, undated timesheets which are not included in this spreadsheet.e