A Rest Home

Registered Nurse, Mrs E

General Practitioner, Dr D

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC04291)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

On 16 October 2006, Mr C (then aged 85) was transferred to a rest home following an admission to hospital for a left hip fracture. Mr C had multiple medical problems including advanced Parkinson's disease with associated cognitive impairment, depression, postural hypotension and compromised skin integrity. His older daughter, Mrs A, lived in Australia, and his younger daughter, Mrs B, had an Enduring Power of Attorney.

The rest home was previously owned by a company which went into receivership. During this period, the previous clinical nurse manager left and the rest home was without a clinical nurse manager for several months until RN Mrs E commenced her employment. A fortnight later, another company took ownership of the rest home, and renamed it.

Over the ensuing months, the new owner sought to introduce new policies, procedures and systems to the rest home, and completed several audits legally required of a new establishment. RN Mrs E was involved in this, and also covered for the facility manager, who was unable to continue working owing to illness.

In April 2007, Mr C developed a pressure ulcer on his right hip. Nursing cares to manage his wound continued throughout the year. Although there were occasional signs of improvement, Mr C's pressure ulcer deteriorated in late December 2007. He also developed a second pressure ulcer on his left hip in January 2008.

In March 2008, Mrs A visited her father and was concerned by the severity of his pressure ulcers. Following review by a gerontology nurse, Mr C was transferred to the public hospital for surgical debridement. Following several weeks of palliative care, he died in hospital.

This report discusses the care Mr C received at the rest home and addresses the issue of whether timely specialist invention could have prevented the rapid deterioration in Mr C's skin integrity. The report also discusses the challenges and responsibilities of a new rest home owner when it takes ownership of an existing facility. A lack of clinical guidance for staff impacted on the care that Mr C received.

Parties involved

Mrs A	Complainant/Consumer's daughter
Mrs B	Complainant/Consumer's daughter & Enduring Power of Attorney for Mr C
Mr C (dec)	Consumer
Dr D	Provider/General practitioner

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

Mrs E	Provider/Registered nurse & Clinical Nurse Manager
Ms F	Previous facility manager
Ms G	Registered nurse
Ms H	Facility manager
A rest home	Provider

Complaint and investigation

On 16 March 2008, the Commissioner received a complaint from Mrs A and Mrs B about the services provided to their father, Mr C, at a rest home. The following issues were identified for investigation:

- *The appropriateness of the care provided by Dr D to Mr C between October 2006 and March 2008.*
- *The adequacy of the information provided by Dr D to Mr C and Mrs B (Enduring Power of Attorney) between October and March 2008.*
- *The appropriateness of the care provided by Mrs E to Mr C between 16 October 2006 and 11 March 2008.*
- *The adequacy of the information provided by Mrs E to Mr C and Mrs B (Enduring Power of Attorney) between 16 October and 11 March 2008.*
- *The appropriateness of the care provided by the rest home to Mr C between 16 October 2006 and 11 March 2008.*

An investigation was commenced on 27 June 2008. Investigations of this nature have been delegated to Rae Lamb, Deputy Commissioner, and this opinion has been formed in accordance with the power delegated to her by the Commissioner.

On 2 September 2008, following a review of the providers' responses, the period of investigation was amended to:

- *The appropriateness of the care provided by Mrs E to Mr C between 1 April 2007 and 11 March 2008.*
- *The adequacy of the information provided by Mrs E to Mr C and Mrs B (Enduring Power of Attorney) between 1 April 2007 and 11 March 2008.*

- *The appropriateness of the care provided by the rest home to Mr C (dec) between 1 April 2007 and 11 March 2008.*

Information reviewed

Information was received from:
- Mrs A
- Mrs B
- Dr D
- Mrs E
- The Quality Assurance Co-ordinator

Mr C's clinical records from:
- The previous rest home owner
- The current rest home owner
- The public hospital.

Independent expert advice was obtained from registered nurse Wendy Rowe (Appendix A), and general practitioner Dr Keith Carey-Smith (Appendix B).

Information gathered during investigation

Background
Mr C, aged 85, had multiple medical problems including advanced Parkinson's disease with associated cognitive impairment, depression, postural hypotension[1] and poor mobility. After his wife died in 2006, Mr C continued living at home on his own. One daughter, Mrs A, lived in Australia, and another daughter, Mrs B, lived in close vicinity to Mr C and held an Enduring Power of Attorney in relation to her father's personal care and welfare.[2] Despite the geographical distance, Mrs A and Mrs B communicated frequently with each other about their father.

Fall in August 2006
On 7 August 2006, Mr C fell while trying to get out of bed, and fractured his left neck of femur.+++[3] He was admitted to the Orthopaedic Department of the public hospital and had surgery the next day (8 October 2006), following which he was transferred to Older People's Health (OPH) for rehabilitation.

[1] A drop in blood pressure that is precipitated by changes in body position.

[2] Since 20 November 2005.

[3] The femur (thigh bone) is a long bone between the hip and the knee. The narrowed end of the femur (neck of femur) is a common site of fracture in the elderly.

Initially, Mr C had lower left pneumonia, which was treated with intravenous antibiotics. During his two months at OPH, Mr C was noted to be delirious and confused from the combined effects of his pneumonia and medication. He also had ongoing problems with postural hypotension, and received input from several physiotherapists and occupational therapists. Owing to Mr C's increased frailty, clinical staff considered it unsafe for Mr C to resume living alone following his discharge from hospital. A support needs assessment was arranged, and Mr C was assessed as having "very high needs". Following discussion with Mrs B, arrangements were made to transfer Mr C to a rest home/hospital for private hospital care.

The Rest Home

The rest home is a 97-bed facility with a dementia unit, and hospital and rest home sections. The two key management staff are the Facility Manager and the Clinical Nurse Manager.

The Clinical Nurse Manager is responsible for providing clinical leadership, guidance and support to nursing and caregiving staff, and for monitoring the provision of clinical care to residents to ensure that the highest standards are being achieved and maintained. She is also responsible for ensuring that there are systems in place to keep family and significant others fully informed of any issues relating to a resident's care, along with maintaining a close liaison with referrers, and ensuring that there is a good exchange of clinical information.

In addition, the Clinical Manager assists and reports to the Facility Manager, who has overall leadership and responsibility for running the facility. The Facility Manager is required to demonstrate a good knowledge of the relevant health legislation and Codes of Practice, and is responsible for putting in place effective facility administration processes. (In the absence of a Facility Manager, this task, along with the management of the facility, is deputised to the Clinical Nurse Manager.)

The rest home has an arrangement with general practitioner Dr D to provide care to all its residents (discussed below). In addition, other health professionals including pharmacists and podiatrists visit regularly.

The rest home was previously owned by a company which went into receivership in 2006. Eight months later, another company took ownership (along with several other facilities) (discussed below) and renamed it.[4]

Dr D

Dr D is a vocationally registered general practitioner with a special interest in geriatrics. He holds a Diploma in Geriatric Medicine. Along with running his own practice, Dr D has been the doctor for the rest home over the past 15 years. All residents undergo a monthly medical review, and Dr D visits twice a week to conduct

[4] Referred to as the rest home in this report — all references to the rest home in relation to events since the purchase include the owner.

this. He also attends at the request of the charge nurse whenever a resident requires additional medical attention.

Transfer to the rest home

On 16 October 2006, Mr C was discharged from hospital and transferred to the rest home. The discharge letter from the OPH registrar noted that Mr C needed help with many aspects of his daily living, and was able to walk up to 10 metres with assistance. The registrar recorded that Mr C's weight "ha[d] increased recently to 74.7kg and continue[d] to climb". The discharge letter was accompanied by a nursing transfer summary which noted that Mr C was on a "normal–soft diet" and was able to walk "short distances with low frame and one assistant watching". In the section titled "Skin integrity", the OPH nurse noted that Mr C's skin integrity was "intact" and that the pressure area on his right heel had healed. The nursing transfer summary also recorded that Comfeel[5] had been reapplied on 15 October 2006, and advised applying Daktarin[6] cream to Mr C's groin.

On admission to the rest home, Mr C was reviewed by Dr D, who noted that Mr C was "well" and in a "stable" condition. Mr C's medical history and list of medications were recorded during this initial review. Nursing staff also conducted an assessment on all aspects of Mr C's support needs. The assessment included a section on "maintaining skin integrity" and Mr C was considered at high risk of tissue breakdown. He was assessed as having a Waterlow score[7] of 17, and the nurse recorded the need to "check skin condition". Mr C's weight on admission was 75.9kg. The nurse also recorded the details of Mr C's medical history and that he required assistance with all aspects of his care. She also noted that Mr C's daughter, Mrs B, held an Enduring Power of Attorney.

Care from October 2006 to March 2007

Between October 2006 and March 2007, Mr C received ongoing assistance with all aspects of his daily routine including showering, dressing and supervision during meal times. To reduce the risk of falls, a staff member assisted Mr C to mobilise using a walking frame. He was nursed on an air mattress (to reduce the risk of pressure ulcers developing) and another mattress was placed beside Mr C's bed as he tended to roll out of bed at night.

The notes during this period contain daily entries from staff members recording their observations of Mr C's progress and the cares given to him. In addition, Mr C was reviewed two to three times each month by Dr D and weighed on a monthly basis. Between November 2006 and March 2007, Mr C's weight ranged from 73.25kg to 70.28kg. His weight remained constant around 70+kg between January and April

[5] Dressing for ulcers.

[6] Anti-fungal treatment for skin infections.

[7] Waterlow score (or scale) gives an estimated risk of a patient developing a pressure sore. The higher the score, the greater the risk. A patient with a score of 10+ is considered "at risk" while a score of 15+ indicates "high risk". Patients with a score of 25+ are at "very high risk" of developing pressure sores.

2007. Mr C also received input from physiotherapy staff, and Mrs B visited on an almost daily basis.

There were two occasions during this period when concerns were noted with Mr C's skin integrity. On 27 October 2006, a wound was noted on Mr C's right heel, which was cleaned with saline and dressed daily. Nursing staff also gave instructions for Mr C to be turned regularly in bed and, on 3 November 2006, staff noted that the wound was "looking better". Three months later, a skin tear was noted on Mr C's right sacrum (on 4 February 2007) which was cleaned with saline and dressed. Nursing staff also instructed that the bandage remain in place for one to two days. The wound in the right sacral area was monitored between 4 and 6 February 2007, following which no further concerns were noted about Mr C's skin integrity until April 2007.

In March 2007, Mr C was reviewed by a dietitian, who prescribed him with an oral food supplement. This was administered daily to Mr C over the remainder of his admission. At times, Mr C was given the supplement twice a day if he had not eaten well that day. In contrast, Mrs B stated that "this was not done" as it "created problems with very loose bowel motions" for her father.

Changes during March–April 2007

On 14 March 2007, RN Mrs E began work as the Clinical Nurse Manager. She qualified as a registered general and obstetric nurse overseas and holds a Bachelor of Nursing degree from Australia. RN Mrs E had previously worked as a clinical nurse manager (including nine months as an acting manager) in two other aged care facilities. Prior to her appointment, the rest home was without a Clinical Nurse Manager for several months. RN Mrs E stated:

> "It was a very stressful experience for staff to be involved in a business that was potentially to close and was then sold. There had also been changes in the management at [the rest home]. The previous Clinical Nurse Manager … had left a month or two prior to my starting. The Facility Manager ([Ms F]) had been appointed by the receivers I believe about late 2006. On my appointment, I reported to [Ms F]."

A fortnight after RN Mrs E started, the new company took ownership of the rest home. As part of the acquisition process, it was agreed that the terms and conditions of employment for staff would remain the same.

Shortly after this, Ms F became unwell and this impacted on RN Mrs E. She recalls:

> "[Ms F] suddenly became unwell around 18th April 2007. She was frequently absent from the facility, resulting in my having to cover for her role. While acting up in the role of Facility Manager (FM) during [Ms F's] absence, I continued to be the sole manager on-call which meant that I was covering the facility 24 hours 7 days a week."

The rest home reported that Ms F took 15 full days of "unexpected" sick leave during June and July 2007. The rest home has confirmed that Mrs E was the key person managing the day-to-day running of the facility at those times.

Ms F's ill health meant she was unable to return to work and she left the employment of the rest home on 10 August 2007.

The rest home advised that on 13 August, three days after Ms F's "official exit", Ms G, an experienced registered nurse, assumed the role of relieving facility manager, and worked with RN Mrs E until a permanent facility manager, Ms H, was appointed on 14 January 2008. Ms G left the rest home on 18 January 2008 after a period of handover to Ms H.

Care from April to December 2007
Between April and December 2007, staff continued providing Mr C with daily cares, which were recorded in his progress notes. Mr C was weighed monthly, and his weight was documented in a weight chart. There were several occasions during this period when Mr C experienced problems with his skin integrity.

On 19 April 2007, Mr C had a monthly medical review by Dr D, who recorded that Mr C was "well". Hyderm was prescribed for "possible scabies" along with another cream for itchiness. On 22 April 2007, staff noted a bruised and slightly broken area[8] on Mr C's right hip. A wound, management chart was commenced and staff documented the actions taken to manage the wound including cleaning it with saline and changing the dressing approximately every two days. However, when the dressing was removed on 29 April 2007, the wound was noted as "looking bad" and the frequency of the dressing was increased to daily.

On 5 May 2007, the wound was reported to be "improving", and staff continued to provide wound care every alternate day until 17 May 2007. While attending to Mr C on 21 May 2007, nursing staff noted that there was "redness around (L) [left] hip" which was "very hard to palpate [touch or feel]". The wound was dressed and liquid Pamol (pain relief) was given.

On 22 May 2007, staff documented that "[Mr C's] condition is deteriorating, he is refusing to eat/drink, only managed few spoons of porridge at breakfast". His dressing was changed and two-hourly turns were commenced. Staff contacted Mrs B, who visited her father at midday. That afternoon, Dr D reviewed Mr C and documented

[8] Pressure areas are prevented by maintaining skin integrity with good nutrition, keeping the skin clean and dry, relieving pressure, preventing skin tears and maintaining mobility. Once the skin has broken, applying appropriate dressings to protect the site, and increased preventative measures are needed, with the addition of pain relief and treatment with appropriate antibiotics if the ulcer becomes infected. The ulcer cannot heal under dead (necrotic) tissue, so the necrotic tissue is removed (debridement) either at the bedside when the dressing is changed, or in theatre as appropriate. It is also important to regularly assess the ulcer for improvement or deterioration, changing the type of dressings used and seeking specialist intervention when necessary.

that he was "unwell 1/7 [1 day], off food/fluid". Dr D also documented that the pressure ulcer in Mr C's right hip had become "infected", and antibiotics and subcutaneous fluids were prescribed. (This was the first reference in Dr D's notes to Mr C's pressure ulcers, and Dr D did not comment on the ulcers again when he reviewed Mr C subsequently over the remainder of 2007. Dr D does not recall nursing staff highlighting any issues with Mr C's pressure ulcers during this time, nor does he recall asking nursing staff about them.)

Between 23 and 25 May 2007, Mr C's food and fluid intake improved. Two-hourly turns were continued, and turn charts were kept from 22 to 25 May 2007. On 24 May 2007, an occupational therapist attended and re-set the air mattress in response to Mr C's complaint that it was "too hard". Heel protectors were placed to reduce the risk of pressure sores developing on Mr C's feet, and the occupational therapist instructed that Mr C continue wearing them in bed.

On 31 May 2007, a meeting was held to discuss Mr C's care. Apart from Mrs B, RN Mrs E and Dr D, it is unclear if anyone else attended the meeting. RN Mrs E stated:

> "There was a multi-disciplinary team meeting [MDT] on 31 May 2007, where [Mr C] was discussed. [Mr C's] daughter [Mrs B] and the GP [Dr D] were present for that. [Mrs B] said there that she knew her father's condition was deteriorating.
>
> At the review [Mrs B] said she was aware of the general decline in her father's condition. She said that she would like some things to be in place, like continued use of the air mattress, two hourly turns, offering fluids as much as possible, assistance with cutting of his meals, [Mr C] to sit in the lazy-boy chair[9] and to go to bed after lunch. All of these things were happening at the time but [Mrs B] wanted this to be reiterated to the staff. This was done by me.
>
> [Mrs B] also mentioned that she would like to see and be informed of any further pressure areas. This information was passed on to the registered nurses to follow through. [Mrs B] at the time did not raise any concerns regarding the care of her father.
>
> After the MDT I did not recall having any conversations with [Mrs B] regarding any issues around [Mr C's] pressure areas or his ongoing care."

Following this meeting, it appears that no further multi-disciplinary meetings were held to discuss Mr C's care.

Over the remainder of 2007, staff continued to monitor the wound on Mr C's right hip. In accordance with the wound management plan, the dressings were changed daily with periodic debridement. In addition to documenting their observations and

[9] Mrs B suggested sitting her father in the lazy-boy chair as she had observed staff leaving him in his wheelchair "for hours on end".

care provided in the progress notes, staff wrote daily in a form titled "Wound Management Plan On-going". Over June 2007, there were several clinical entries noting that there was considerable oozing from the right hip wound, which was described as "sloughy" and "smelly". By late June 2007, staff noted that there were "slight" improvements in Mr C's right hip wound, and over July to September 2007, there were several entries from nursing staff stating that the wound was "healing well". Staff also observed improvements in Mr C's food and fluid intake. This was reflected in Mr C's weight, which increased from 65.55kg in July 2007 to 66.20kg in September 2007.

From September 2007 onwards, Mr C became wheelchair bound, and a hoist was used to lift him between his bed and wheelchair. Mr C did not regain his mobility after this. According to Mr C's family, this was because he was not mobilised regularly and he was not receiving physiotherapy review.

On 3 October 2007, Mr C suffered a 1cm skin tear on his right arm as a result of wrestling with a staff member who was helping to dress him. The skin tear was dressed and an incident form was completed. Staff informed Mrs B, who visited her father the next day and apologised for his "aggressive behaviour at times". On 4 October 2007, Dr D saw Mr C as part of his monthly review and noted that he was "well" and "happy today". Later that month, staff weighed Mr C. His new weight of 64.6kg was recorded and staff noted that this represented a weight loss of 2.4kg from September 2007.

Over November and December 2007, staff continued providing Mr C with his usual cares. His weight remained constant during this period. On 3 December 2007, staff noted rashes on Mr C's entire body. Locoid cream (corticosteroid) was applied and, ten days later, nursing staff documented (on 13 December 2007) that the rash had improved. On 28 December 2007, whilst changing the dressing on Mr C's right hip, nursing staff noted that the wound was "not improving". On 31 December, the wound was described as "not healing well".

January to March 2008

From 2 January 2008 onwards, Mr C needed twice daily changes of the dressings on his right hip. On 8 January 2008, the duty nurse noted that there was "no improvement" to the wound and reminded staff to continue turning Mr C regularly in bed. On 10 January 2008, Mr C was reviewed by a locum doctor as Dr D was away. The locum doctor described Mr C's right hip wound as "deep + non-healing — like a deep crater". The locum doctor advised continuing with "all pressure care treatments" and to keep Mr C off his right hip. A prolonged course of antibiotics (doxycycline) was prescribed.

On 11 January 2008, the duty nurse documented that the right hip wound was "not healing well, has deteriorated with lots of dead tissue". In addition, the duty nurse noted the development of a pressure area on Mr C's left hip which she described as "other side is breaking down". Staff were reminded to continue with regular turns.

Over January 2008, there were several clinical entries recording that Mr C "was eating and drinking well". Despite this, Mr C lost approximately 3.6kg and weighed 60.65kg in January 2008. This was Mr C's lowest recorded weight during his admission and it appears that he was not weighed again in February and March 2008.

On 4 February 2008, a monthly medical review was conducted by Dr D who stated:

> "When I next saw [Mr C] on 4 February, I noted that he had pressure sores on both hips. It is not exactly clear to me when the sore on his left hip developed, although it seems likely that this developed as a result of positioning him on his left side in an effort to avoid pressure on the right hip. My notes at that time indicate that the wounds were 'moist and deep, not mucky or red, not painful'. A wound swab had shown a mixed growth of bacteria and he was already still receiving the antibiotic prescribed in January. I saw no reason to change his management at that time and my plan was to 'continue dressings'."

A week later, Dr D reviewed Mr C again, and stated:

> "I reviewed the R [right] hip wound (which was the worst) again on 12 February when it was noted as being '3cm x 2cm, moderate ooze, no definite signs of infection'. After discussion with the nursing staff regarding further management options the dressings were changed to include an absorptive dressing called Kaltostat,10 with all pressure relief measures to continue."

Thereafter, Dr D stated that he "did not personally review [Mr C's] wounds again". Mrs B was "very surprised" that Dr D did not do so and said:

> "I would think that with how bad they were, it would have been a priority to check them to see if there was any improvement.
>
> The care of our father was in his hands so [we] feel let down by this."

On 3 March 2008, Mr C was visited by his daughter, Mrs A, from Australia. (Prior to her visit, Mrs A was informed by Mrs B that their father had developed pressure ulcers on both sides of his hips.) Mrs A was present when the duty nurse changed the dressings on her father's hips that day. Mrs A recalls:

> "I was upset and distressed to see how extremely horrific they were, the one on the right had formed a deep channel and the one on the left was as big as the palm of my hand. I immediately requested to see the doctor ([Dr D]) who was treating my father. I had a meeting with him on Tuesday 4 March 2008 at 3pm.

[10] Kaltostat is a type of dressing for the management of heavily exuding wounds. It consists of an absorbent fibrous fleece composed of sodium and calcium salts. The dressing is presented as a flat non-woven pad for application to surface wounds. In the presence of exudate or other body fluids containing sodium ions, the fibres absorb liquid and swell and calcium ions present in the fibre are partially replaced by sodium, causing the dressing to take on a gel-like appearance. This overlays the wound and provides a micro-environment that is believed to facilitate wound healing.

> During this meeting I asked him what treatment had been done and was informed that a four-week course of antibiotics had been prescribed in January 2008 — date unknown and daily dressings. When I requested that a specialist or District Nurse proficient in wound control be called in to assess these bedsores he basically told me that there was no need and the bedsores were caused by my father's skin breaking down. In this meeting I also asked how these had occurred as my father was not bed-ridden and had a pressure mattress on the bed and was supposed to be … turned regularly when he was in bed. He stated that these things happened, which to me was not the answer I was looking for. I formed the impression that he had not looked at my father's bedsores recently as I cannot understand how a medical person could let them get to the state they were. When I insisted that they were looked at by someone else the RN told me about wound control nurses from [the public hospital] that would visit and examine him. I requested that this be done immediately knowing my time in New Zealand was short."

Dr D stated:

> "I certainly do recall meeting with [Mrs A] on 4 March 2008 ... This was the first time anyone from the family had expressed to me any concern about the situation. Her concerns were treated seriously and empathetically. I certainly discussed at that point the fact that I believed his overall poor state of health and limited life expectancy made palliative management the best, and in my mind the only, course of action. [Mrs A's] request for a further opinion was responded to appropriately with ready agreement to ask the [DHB] wound care nurse specialist to visit, which was promptly arranged."

Review by wound care specialist

Following the meeting, nursing staff contacted the public hospital to arrange a wound care specialist review for Mr C. On 10 March 2008, gerontology nurse specialist saw Mr C. In her referral letter to the public hospital, she recorded:

> "I visited [Mr C] today at the facility and met the daughter there. It appears that the wound on the left hip developed in January this year but the one to the right hip has been there for a year, they stated that it did heal for a while then broke down again. On my examination of the wound there was exudate +++ and the Registered Nurse reported that the wounds sometimes needed dressing 3 times a day due to the amount of exudate.
>
> I swabbed the wound on [Mr C's] right hip and was able to insert nearly the full length of the swab into the wound ? hitting bone. The exudate from this hip is foul green and I am obviously concerned that he may have osteomyelitis.[11] He has been on a ripple mattress and high protein diet is documented but has nevertheless lost 5kg in the last 2 months. He additionally

[11] Inflammation of the bone caused by infection.

> appears pale ?anaemic and his daughter said that yesterday [9 March 2008], his conjunctiva were jaundiced in appearance. His latest blood tests were performed [in] August 2007 and the last swab in January showed a mixed growth. …"

Admission to hospital
Later that day, Mr C was admitted to the Older People's Health ward of the public hospital for a review of both hip ulcers. These were surgically debrided on 15 March 2008 — the wound on the left hip was cleaned and the right hip wound required debridement of necrotic tissue. Vacuum dressings were applied thereafter.

Following a discussion with clinical staff of the options, Mr C's family agreed that a palliative approach was appropriate. Over the next few weeks, Mr C received comfort cares at the public hospital and subsequently died. His cause of death was recorded as "sepsis, chest infection and infected bilateral hip ulcers".

Other matters

Referral to specialists
At the time of Mr C's admission, the rest home did not have a documented process in place for referring residents with pressure ulcers to an external nursing advisor for assessment. This has subsequently been rectified and a procedure put in place (discussed later).

In relation to input from a dietician, it appears that there were no further referrals following the dietician's review of Mr C in March 2007. RN Mrs E stated that she "d[id] not believe a dietician would have altered what was being done with Mr C". A procedure has since been put in place to refer residents to dietitians (discussed later).

In addition, Dr D did not consider seeking specialist advice from a gerontologist at any stage of caring for Mr C as he "believed [Mr C] was being managed appropriately and saw no reason to think a gerontologist would alter [Mr C's] management". Dr D considered that the management of Mr C "fell well within the scope of practice that [he] felt experienced with and qualified to provide without needing to refer for any further input". Dr D stated:

> "I would like to make it very clear that failure to make any earlier referral for gerontology assessment was ***not due to neglect or indifference*** regarding [Mr C's] ulcers, but was an active and considered decision taken with due regard to his overall condition."

Communication with family

A multi-disciplinary team meets periodically to review the progress of each resident at and residents' families are encouraged to attend these meetings. This practice was in place at the time of Mr C's admission. Under the previous policy, multi-disciplinary meetings were held annually whereas the new owner's policy is for twice a year meetings. In addition to the meetings, the rest home encourages residents' families to spend time at the facility and to "treat it like home". In terms of the communication between the rest home and Mr C's family, RN Mrs E stated:

> "… I did not see a lot of [the family]. It may have been that [Mrs B] came in the late afternoon or evening, after my work had finished (I did am shifts). …
>
> I was aware that the nurses had been liaising with the family (including regarding pressure areas). There are [a] number of references in the clinical notes to staff having discussions with [Mrs B], including regarding [Mr C's] pressure areas. If there is a specific event, the nurse on duty is expected to contact the family without delay. There is also a specific nurse allocated to each patient for ongoing clinical input including multi-disciplinary reviews."

Mrs B commented:

> "I did visit in the afternoon and evening but was able to be contacted anytime and could go when called. I feel that … RN [Mrs E] should have contacted me more often not wait for me to seek her out. Every time I went to visit Dad I asked the RN who was on duty how his hips were going. The reply was they were improving which we now know was not true. I did not like to ask to have Dad undressed so I could see the wounds but believed what I was being told was the truth."

In relation to the discussions about Mr C's pressure ulcers, Dr D commented:

> "… It is not my practice to routinely inform family members of, or discuss with them issues such as the presence of ulcers and pressure sores unless they are causing particular concern. Certainly up until the end of 2007 there was no major concern. I was satisfied with the care being given and had no reason to believe that any further measures were likely to be beneficial, hence no specific discussions were initiated with [Mrs B].
>
> …
>
> I pride myself as being very proactive in initiating discussion with residents (where they are capable) or family (where they are not) regarding issues of care where ***I feel there are important decisions to be made or options to be considered***, especially regarding end of life care and decisions between active and palliative care. I reiterate that I did not believe that further options such as referral for gerontology review were likely to be beneficial, hence this was not raised.

…

> ***Notwithstanding all of the above***, I am prepared to concede that, ***in retrospect***, earlier consideration of referral for specialist assessment of [Mr C's] hip ulcers, perhaps by raising this possible cause of action with his power of attorney [Mrs B], may have ***been preferable***, although this would not have been likely to change the eventual outcome."

Challenges during change of ownership

During the bulk of Mr C's admission, the rest home was undergoing a period of transition. Mr C arrived the same month its previous owner went into receivership. Six months after Mr C was admitted, there was a new owner. In addition to the changes in management staff (discussed earlier), the rest home explained that they faced various challenges after taking ownership of the facility and several other facilities in 2007. These included the need to roll out and educate staff on policies, procedures, systems and processes, as well as the protracted appointment process for a new Facility Manager.[12]

RN Mrs E stated:

> "Obviously the arrival of [the new owner] resulted in the need for the introduction of new policies and procedures. These were focused on ensuring that the various facilities were running well and providing good care. The introduction of these policies took a considerable amount of my time.
>
> My focus (and that of [the rest home]) was also on the external audit process. Effectively I was relying on the team of registered nurses, which was fully staffed at the time, to provide competent care to patients. At the time [Mr C] was a patient I had no grounds to believe that was not happening.
>
> There were about 7 registered nurses covering the shifts. I was certainly not getting reports from any of them about problems with the performance of others of them, for example."

RN Mrs E's lawyer explained:

> "… Realistically, the audits had to be a priority as a failure on that front could have led to the facility being closed down."

The rest home stated:

> "During the first 6 months under ownership with [the new owner], [the rest home] underwent a DHB [District Health Board] contract audit on 1st August

[12] Shortly after Ms F left in August 2007, the rest home advertised for another facility manager but no permanent appointment was made until January 2008. As mentioned previously, Ms G was the relieving facility manager between 13 August 2007 and 18 January 2008.

> 2007 and a full certification audit on 18th September 2007 (as a requirement of the provisional certificate following acquisition). The energy required from the [rest home] management team to prepare and manage these audits as a matter of priority, took considerable focus and may have been distraction from normal day-to-day operational activity. This coupled with implementing various change processes throughout the facility meant that areas of the Clinical Managers role may have been given less attention than may have been required."

The rest home subsequently qualified this by stating that it does "not entirely agree that RN Mrs E was unable to monitor and supervise staff adequately owing to competing demands on her time" as "both RN [Mrs E] and [Ms G] [the relieving facility manager] worked with staff to prepare for the certification audit". However, the rest home also acknowledged that Ms F, the facility manager, took 15 days' sick leave prior to the August 2007 audit, and advised that Ms G did not start until 13 August 2007.[13]

The rest home stated that shortly after commencing her role, Ms G "regularly advised" RN Mrs E that all on-call work Monday to Friday was Ms G's responsibility. Mrs E was encouraged to remind staff of this and to refer any on-call contact received onto Ms G.

Remedial measures
Since the events in question, the rest home, RN Mrs E and Dr D have made several changes in their practice as discussed below.

The rest home
The Quality Assurance Co-ordinator stated:

> "… [S]oon after receipt of [Mrs A's] complaint,[14] [we] sent a support team of senior RNs to the facility for four days to work alongside the Facility Manager [Ms H] and Clinical Manager [Mrs E]. One to one 'coaching' in strategies to assist monitoring staff practice was carried out with both managers at this time. Intense education for nursing staff was also implemented.
>
> During the support team's visit, gaps in documentation, the communication processes and resistance to change between different levels of care staff were identified. Strategies to address these issues were discussed and implemented in conjunction with the Clinical and Facility Managers.

[13] A month before the further audit.

[14] During her visit in March 2008, Mrs A telephoned the Quality Assurance Co-ordinator to discuss the care that Mr C had received. On 23 April 2008, she responded to Mrs A's concerns and outlined several remedial measures taken, which were reiterated in a subsequent letter the Quality Assurance Co-ordinator sent this Office.

> One of our most senior and respected nurse clinicians, (formally within the Care Services Team) worked along side the Clinical Manager and nursing staff over a period of 3 months providing regular one on one coaching and hands on support and guidance in standards of care and professional care delivery. Over this period the following has occurred:
>
> - Practice reflection with qualified staff in a variety of forums, e.g. Qualified staff meetings, education sessions and personal conversations.
>
> - One to one coaching for the Clinical Manager and each RN within the facility.
>
> - Four Senior Caregivers have been identified as [Clinical] Assistants chosen for their leadership abilities and high level of care and commitment to their roles. The care assistants have been trained to assist the RNs (working under their supervision) carrying out selected tasks.
>
> - Education on leadership, communication, time management, delegation skills and reporting has also been provided.
>
> - A caregivers' course incorporating 11 modules specific to the care of residents will commence at the facility on 30th July 2008.[15]
>
> - Where staff practice deficits have been identified, an individual development plan has been prepared and implemented and is being monitored by the management team within the facility."

The Quality Assurance Co-ordinator concluded:

> "[The rest home] acknowledges some gaps in the support and assistance for the Clinical Manager during the absence of a permanent Facility Manager.[16] The operations team expected that a Facility Manager [the rest home] would be appointed within a short timeframe and when this process became protracted we anticipated that [Mrs E], an experienced clinical manager was able to cope with the clinical responsibilities of her role. Once issues related to staff practice and accountability became clear, support and leadership was quickly provided.
>
> Again we wish to extend our sincere apologies to [Mrs A], her sister [Mrs B] and their family. …"

[15] A copy of the timetable and proposed programme for the caregivers' training was provided by the rest home during the investigation.

[16] The rest home clarified that there was a relieving facility manager between August 2007 and January 2008.

RN Mrs E

RN Mrs E's lawyer submitted on her behalf:

> "We are concerned that [the rest home] did not do enough to support [Mrs E], in carrying out two full time jobs for an extended period. …
>
> … There is no suggestion that [Mrs E] was not capable of carrying out her clinical responsibilities, the issue was whether she would reasonably be able to do them when she was carrying out two full time roles at one time. In our view it is impossible to carry out all the functions of two jobs that require around 8 hours a day each, unless one is prepared and able to work 16 hours a day, or 80 hours a week. Realistically, some functions must not be completed."

RN Mrs E stated:

> "I acknowledge that while I was covering two roles (or part of them) I could not provide a high level of support to the nurses. Now that I am able to do it, I have outlined the changes below.
>
> I am now able to work alongside with the nurses, supervising nurses and providing clinical support.[17]
>
> I have written and introduced a protocol[18] for reporting on and managing wounds.[19]
>
> I view all wounds of whatever origin on a weekly basis and also as required, more frequently and advise nurses of the appropriate dressings. I also refer to Gerontology Nurse Specialist for further advice. Once we have implemented that advice, and if the pressure areas remain of concern, we ask the specialist to review the patient personally.
>
> I have set up a folder for the registered nurses with relevant policies and appropriate forms for Allied Health referrals (including dieticians, physiotherapists, speech language therapists and gerontology nurse specialists) with all contact details. The nurses have been using this folder effectively.
>
> I have done a reflective study following [Mr C's] incident. I also got the RNs [registered nurses] to do the same study.

[17] The rest home's view is that RN Mrs E "was adequately supported to carry out the functions of her role as Clinical Manager" as a relieving facility manager was appointed from 13 August 2007 to 18 January 2008, and a permanent facility manager from 14 January 2008.

[18] According to the rest home, this "is not strictly correct". The steps staff were to follow in reporting changes to a resident's skin condition/wounds are in fact instructions rather than a "protocol" and RN Mrs E's actions in this regard were in response to an internal review conducted.

[19] A copy was supplied by RN Mrs E to this Office, and is attached as Appendix C.

> I have purchased wound care products as per the gerontology nurse specialist's advice. Some of these products could not have been purchased early in my time at [the rest home] as [the new owner] just took over from the receivers and the financial position needed to be sorted out. Medical supplies were previously managed by a non-nursing staff member. I took over their management from April 2008.
>
> I am focusing on documenting instructions I have given to the RNs for any ongoing care, including nurses to liaise with the GP.
>
> I have increased my liaison with the GP directly if a resident's concern is brought to my attention.
>
> As part of the wound management protocol, nurses are to ensure that the GP sights all wounds and advises on the same.
>
> RNs are also to ensure that families are informed of the progress of the resident's conditions and make sure it is followed through.
>
> I offer to become the key contact person for some families to keep them informed with what is going on with their loved ones.
>
> I organized an education session on wound management for all registered and enrolled nurses in September 2007, and in March 2008 the support team from [the rest home] also did an education session on wound management. Smith & Nephew (as product manufacturer) also provided a nurse to conduct education for RNs in May 2008. Another session was arranged for an air mattress producer to run a session on pressure area cover and the use of pressure release mattresses.
>
> The [General Manager] has recently met with all RNs to stress the importance of staff being clinically focused and having ongoing education."

RN Mrs E concluded:

> "I acknowledge that circumstances were not ideal at the time [Mr C] was at [the rest home].
>
> However, I do believe that [Mr C] was provided with a reasonable standard of care. I was certainly not aware of any concerns regarding [Mr C] which were not being dealt with.
>
> …
>
> I would like to pass on my condolences to [Mr C's] family."

Dr D
Dr D stated:

> "I cannot deny that this whole experience has affected my practice. I have spent many hours considering my actions and questioning whether my judgement should have been different with regards to seeking a further opinion sooner. While I remain unconvinced that earlier referral would have resulted in a different outcome, I have nevertheless lowered my threshold for referral of pressure sores. There has since been one other patient at [the rest home] with a chronic heel ulcer which I have referred to the wound care nurse specialist where I might not have done previously. …"

Dr D concluded:

> "I am prepared to ***apologise to [Mr C's] family*** for any distress they feel was caused by my making a different judgement at the time."

Responses to provisional decision

Mrs B
Mrs B clarified several matters, which have been incorporated into the "information gathered" section of my report.

Mrs A
Mrs A clarified several matters, which have been incorporated into the "information gathered" section of my report.

In relation to the medical care Mr C received, Mrs A commented:

> "[Dr D] stated that he believed Dad's treatment was being managed appropriately and failure to refer him for gerontology assessment was not due to neglect or indifference on his part. I disagree with that statement. I consider that not to have checked Dad's pressure sores after the 12th Feb 2008 implies GROSS NEGLECT AND INDIFFERENCE. Also during our discussion at no point did he discuss with me Dad's limited life expectancy or palliative care management. My sister and I never expected our Dad's life to come to an end in this abrupt way. It was only after he had been admitted to [Hospital] and discussions with his doctors there that we were aware that these ulcers had become life-threatening. …"

In terms of managing Mr C's skin integrity, Mrs A stated:

> "… [T]o my knowledge his wounds were never dressed more than once a day even when I requested that he be changed as he hadn't been taken to the toilet

enough."

Mrs A concluded:

> "I am pleased that changes have been implemented for the care of residents at [the rest home] but hope that regular follow-up checks will be made of this facility."

RN Mrs E
RN Mrs E and her lawyer clarified several matters, which have been incorporated into the information gathered section of my report.

In relation to the nursing care provided, RN Mrs E commented:

> "I still believe that the nurses, who were carrying out [Mr C's care], were providing the appropriate treatment to him. …"

RN Mrs E's lawyer submitted that RN Mrs E's care was reasonable given the circumstances she was working under.

RN Mrs E accepted that the documentation of Mr C's care "was not as thorough as it could have been" and outlined various remedial measures to address this:

> "… I have set up a system for clinical file audits. I review a number of files each month. I take back issues which have arisen from the audits to the RN meetings for education purposes. [The rest home] also has a policy requiring all files to be checked within a six month period.
>
> We have been working on changing to a client focus in documentation and getting a sense of carryover of reports (so that a sense of what is happening from one shift to another), is reflected in the documentation. These are fairly significant changes for some staff, but I am continuing to work with them on what is needed.
>
> I am also myself making more frequent entries in the clinical notes to reflect when I am more directly involved in care."

In relation to the products used to dress Mr C's pressure ulcers, RN Mrs E stated:

> "I believe that the most appropriate products which we had at the time were being used. The nurses were using Kaltostat for [Mr C]. The doctor was aware of this product choice and did not object to it. My understanding is that Kaltostat did not worsen the wound, although it may not have caused such fast healing as other products (such as Allevyn[20] products).
>
> However, this is an area where there were financial constraints as a result of receivership of [the previous owner] and the transition to new ownership. We had been told that we were not to buy expensive products.
>
> There was also the situation where a non professional was ordering supplies. During the time when I was undertaking two roles, it was obviously impossible for me to consider taking on any functions in addition to those two roles. However, when I returned to only carrying out the clinical nurse manager role, was able to take on the ordering responsibilities.
>
> I have more recently been able to purchase more expensive products (for example, about $120 for 10 pieces of Allevyn silver), as recommended by the wound nurse specialist, and have found these products to be very effective."

RN Mrs E confirmed that changes have been made to the management of residents' nutrition in light of Mr C's case:

> "We (as part of the wider [rest home facilities]) have instituted a three monthly review of weight calculations, to look for patterns of increases or decreases. If such a pattern is noticed (either at that 3 monthly review or sooner), the RNs do a comprehensive nutritional assessment, which can result in a referral to a dietitian for review.
>
> I have also set up a folder for referrals to the dieticians. Either the RN can refer the case to me for referral to a dietitian or they can make the referral directly themselves.
>
> … I accept that there were a number of things regarding [Mr C's] care which could have been done better. I have been and continue to be committed to improving the standards of care which our residents receive."

RN Mrs E has reflected on her communication with the family and with other residents' families, and said:

[20] Allevyn is a type of wound dressing for managing exuding wounds. The wound contact surface of the dressing is covered with a perforated film, designed to prevent the dressing from adhering to granulating tissue. The foam is highly absorbent, and strike-through is prevented by the semi-permeable film backing. When applied to an exuding wound, the dressing will absorb excess fluid but maintain the wound surface in a moist condition providing a micro-environment that is conducive to healing.

> "… I recognise the importance of keeping families closely informed of developments and involving them in the major decision making process.
>
> Now that I am able to focus on the Clinical Nurse Manager role, I am the key liaison person for most families and I organise and co-ordinate all multi-disciplinary team reviews which families participate in."

RN Mrs E concluded that as a result of this case, she is now "much more focused on supervision of staff and direction of care, and documentation".

The rest home
The Quality Assurance Co-ordinator responded on behalf of the rest home and clarified several matters, which have been incorporated into the "information gathered" section of my report.

In relation to the challenges facing the company after it acquired the rest home, she commented:

> "When [the new owner] acquired the rest home, it was in receivership as part of the [previous company]. While we have invested considerable energy and time to bring it up to speed, inevitably inheriting a facility with a difficult history does not result in change overnight as we are required to observe due employment processes. Culture and policies take time to be instilled.
>
> We are mindful of our responsibilities to the resident/consumer, but this is the practical reality we face and ultimately we believe the consumer is better served in the medium term by robust organisations making this commitment than not.
>
> We acknowledge that there was a failure in delivery of good clinical care within the facility to [Mr C], however we do not accept that [we] '… did not take adequate steps to support [Mrs E] …'"

The Quality Assurance Co-ordinator advised that the amount of time that RN Mrs E was unsupported was significantly shorter than provisionally reported by HDC. For example, Ms F was absent 15 days in total for unexpected sick leave. Further, the relief facility manager, Ms G, began work only three days after Ms F's "official exit".

The Quality Assurance Co-ordinator stated:

> "We acknowledge that it is [our] responsibility to ensure that the residents within our facilities continue to be well cared for whilst changes are being implemented and to support staff in key management positions during the transition period however given [Mrs E's] previous clinical and management experience within the aged care sector, [we] anticipated that [Mrs E] was able to continue to manage the clinical responsibilities of her role in the facility and request advice or assistance should she feel that she needed this."

The Quality Assurance Co-ordinator also advised that RN Mrs E attended clinical manager seminars on 24/25 September 2007 and in March and September 2008 where she would have been provided information about ways to manage the role.

The Quality Assurance Co-ordinator outlined additional improvements implemented since these events:

"• While monthly reporting of clinical indicators by facilities continues, there is now also shared quarterly benchmarking by [the rest home] with [two overseas] facilities regarding pressure sore rates and grades.

- A revision of the Pressure Sore Data Collection sheet to capture the number, nature and grade of pressure areas each month, identifying also facility acquired where a resident has been admitted with a pressure area.

- Revision of the Wound Assessment and Management policy and clinical forms to include grading of pressure areas and indicating assessment of pain at wound site.

- Braden Risk Assessment Teaching resource was developed and implemented in September 2008 and was introduced at the 6-monthly Clinical Managers' seminars. The resource assists qualified staff in the appropriate use of the assessment tool and focus on prevention of pressure areas.

- Development and distribution of 'Say No to Ulcers' posters to facilities. The acronym NO ULCERS goes through the various aspects of a resident's condition e.g. Nutrition / Observation / Up (& walking/turning) etc to visually cue all care staff."

The Quality Assurance Co-ordinator concluded:

> "At the time of the internal review at this facility, a Corrective action plan was developed to address the gaps identified at the time. The Facility and Clinical Managers have both worked hard to implement each of these corrective actions and [the rest home] has since carried out 2 follow-up visits to ascertain progress and completion of these corrective actions. We are pleased to advise that there has been significant improvement not only in the care being provided within the facility, but also the level of responsibility taken on by all care staff.[21] …"

Dr D

Dr D confirmed that the information gathered is accurate. He accepts that he should have asked nursing staff about the condition of Mr C's ulcers following his first

[21] A copy of the most recent corrective action plan following the site visit on 22 January 2009 was provided to this Office.

reference to them on 22 May 2007, and informed Mr C's family in early 2008 that Mr C's health was declining.

Dr D has written to the family apologising "sincerely" for both omissions.

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 4
Right to Services of an Appropriate Standard

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

Clause 3 Provider Compliance

(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

Opinion: Breach — RN Mrs E

Mr C's nursing needs were numerous because of his age, medical history and reduced mobility. Over time, he became increasingly debilitated, deteriorating both physically and mentally, and it was increasingly challenging to nurse him given such complex requirements. In addition, Mr C's admission coincided with a period of considerable upheaval, and RN Mrs E faced significant challenges in her role.

Nonetheless, as a health care provider subject to the Code of Health and Disability Services Consumers' Rights, and as clinical nurse manager, RN Mrs E was required to provide Mr C services with reasonable care and skill (Right 4(1)). In my view, RN Mrs E did not provide Mr C with appropriate care in the following areas:

Management of Mr C's skin integrity
Mr C was known to be at a high risk of developing pressure ulcers. On admission, he was assessed as having a Waterlow score of 17, and was nursed on an air mattress to reduce the risk of pressure areas developing. In April 2007, he developed a pressure area on his right hip, which was dressed daily. In addition, two-hourly turns were commenced, and a hoist was used for transfer from September 2007 onwards when Mr C became immobile. These were appropriate measures. However, although Mr C's

right hip wound showed signs of improvement over 2007, it further deteriorated in late 2007. In January 2008, he also developed a pressure area on his left hip.

As the clinical nurse manager, RN Mrs E was responsible for guiding and directing nursing staff and caregivers in their care of Mr C, and seeking specialist input where necessary. In relation to wound care management, this included carrying out a comprehensive assessment of Mr C's wounds, formulating an ongoing care plan, and ensuring that staff documented their actions to monitor pressure areas (which should include describing their observations and any significant changes in the progress notes), and consulting a wound care specialist for advice. The documentation does not show that Mr C's wounds were managed satisfactorily.

My expert nurse, Wendy Rowe (a registered nurse with 23 years of nursing experience including aged care nursing and as a clinical nurse manager) noted that there were "inconsistencies in the daily documentation" by nursing staff, and that a "poor choice of product[s]" were used to dress Mr C's wounds. Ms Rowe also considered that staff had insufficient knowledge of wound healing "[a]s evidence[d] by [the] inappropriate completion of forms" and because the left hip ulcer that Mr C developed in January 2008 was "not clearly identifiable in the progress notes" (although staff documented it in the wound records). By that stage, the deteriorating pressure areas on both Mr C's hips had become very difficult to manage, and were "most unlikely" to heal. Nevertheless, input from a wound care specialist would still have been helpful in guiding nursing staff on practical measures they could take. It is unfortunate that there was no documented process in place at that time for initiating this, and that the referral to the wound care specialist took place only after it was requested by Mr C's daughter, Mrs A.

Taking into account the above, my view is that there were deficiencies in the care and management of Mr C's ulcers for which RN Mrs E, as clinical nurse manager, was responsible.

Management of Mr C's nutrition

Mr C required assistance with feeding, and there were several occasions when he was not eating or drinking and was unco-operative. An oral supplement was prescribed to boost his daily calorie intake. The rest home has advised that at times, this was given twice a day if he had not eaten well (a point Mr C's family disputes). His weight was monitored monthly, and there were several instances in 2007, and in early 2008, when he was noted to have lost weight.

Mr C's nutrition was not well managed. There is no evidence of a comprehensive nutritional assessment completed by nursing staff when it was evident from late December 2007 onwards that Mr C was losing weight and his hip ulcers were not healing. According to Ms Rowe, such assessment could be carried out on a three-monthly basis to ensure that adequate nutritional status is being maintained. My expert considered that a referral to a dietician "would have been of benefit at this time to review the [oral] supplement being used … and to ensure adequate daily caloric

intake". Ms Rowe advised that monitoring a resident's weight monthly was insufficient as Mr C's case was complex and he continued to lose weight even when clinical entries indicate that he "was eating and drinking well". Again, it appears that there was a lack of attention being paid to what was really happening in regards to Mr C. As discussed, it was RN Mrs E's job to monitor the clinical care provided to residents and to obtain specialist input if the situation warranted it.

I consider that RN Mrs E did not fulfil her responsibility and ensure that Mr C's nutrition was managed adequately. RN Mrs E has accepted this criticism and implemented various remedial measures including three-monthly review of weight calculations, conducting a comprehensive nutritional assessment where there is a trend of weight increase or decrease, and referring residents promptly to a dietitian. While these are appropriate corrective actions, the fact remains that she did not provide sufficient oversight in Mr C's case.

Documentation

Health professionals are required to document accurately and fully a resident's observations, progress, and the findings from any clinical examinations conducted. In a private hospital setting, the nurse manager is responsible for supervising and ensuring that nursing and caregiving staff keep good notes since documentation is an essential part of good quality care.

The deficiencies in Mr C's care were also reflected in the documentation by RN Mrs E and her team. Although there were daily clinical entries in Mr C's progress notes, my advisor commented that the "entries were not client-centred at all" as they "did not indicate [the] plan for [the] client nor did it describe [the] ulcers' progress/or deterioration". In addition, there were no entries by RN Mrs E herself in the progress notes on a daily/weekly basis nor was there any indication that she had read or reviewed Mr C's progress notes regularly. The lack of input from RN Mrs E may have resulted in staff not completing or dating assessment forms, which also reflected a "lack of knowledge and understanding pertaining to wound care". My advisor also commented that there was an "inappropriate level of documentation by all staff" as reflected in the choice of words used in the progress notes to detail Mr C's care. RN Mrs E accepts that her documentation was "not as thorough as it could have been".

Conclusion

In mitigation, I acknowledge that RN Mrs E took over the role of Clinical Nurse Manager at a time when the rest home was undergoing a considerable period of transition. Shortly after commencing employment, RN Mrs E also had to assume the responsibilities of a facility manager and functioned in a dual role when Ms F was unwell and until a relieving facility manager came on board to assist her in mid-August 2007. As a result, she was unable to provide a high level of support and guidance to nursing and caregiving staff — something she has acknowledged. I have considerable sympathy for the situation RN Mrs E found herself in, and believe responsibility also lies with the rest home (discussed later). Nonetheless, RN Mrs E was the clinical nurse manager and Mr C had significant clinical needs. She was

responsible for ensuring that his care was managed appropriately and should have alerted her employers if she could not do so. Ms Rowe advised:

> "[The] CNM [clinical nurse manager] is responsible for the standard of care including wound care management of all RNs [registered nurses]. This includes a comprehensive assessment, ongoing plan of care, appropriate documentation to show evidence of ongoing monitoring of wounds which includes descriptions of significant changes in the progress notes. None of these are evidenced in the documentation provided."

Overall, I consider that RN Mrs E "lacked insight" into the level of care Mr C required, and did not fulfil her responsibilities and manage his care appropriately. She has failed to prove that her actions were reasonable even taking into account the constraints she faced. Her care of Mr C breached Right 4(1) of the Code, and would be viewed with moderate disapproval by her peers.

Opinion: Adverse comment — Mrs E

Adequacy of information

Mrs B held an Enduring Power of Attorney (EPOA) in relation to Mr C's personal care and welfare — an arrangement formalised some 18 months prior to Mr C's admission to the rest home. Mrs B was therefore entitled to receive full information about her father's care in order to make decisions on his behalf about his personal care and welfare. This is affirmed under Right 6(1) of the Code.[22]

My expert, Ms Rowe, advised that the clinical nurse manager has overall responsibility for ensuring that information is provided to the resident and the resident's EPOA. Mrs B visited her father on an almost daily basis and was closely involved in his care. She participated in the multi-disciplinary meeting in May 2007, and attended promptly whenever staff contacted her to discuss their concerns about her father's care.

From reviewing Mr C's notes, I am satisfied that staff generally kept Mrs B informed about Mr C. However, RN Mrs E does not recall having any discussion with Mrs B about her father's pressure areas or ongoing care following the multi-disciplinary team

[22] Right 6

Right to be Fully Informed

(1) Every consumer has the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

a) An explanation of his or her condition;

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option …

meeting on 31 May 2007. This is notwithstanding Mrs B's request that she be updated about her father including his skin integrity. It is also unclear what discussions RN Mrs E had with Dr D about the condition of Mr C's pressure areas between May 2007 and January 2008 since any discussions of this nature were not recorded in the nursing and medical notes. There was also a delay in notifying a doctor about the deteriorating ulcer in Mr C's right hip, and he was only reviewed by a locum doctor on 10 January 2008, a fortnight after the deterioration was first recorded (on 28 December 2007).

My expert general practice advisor, Dr Keith Carey-Smith (a vocationally registered general practitioner with over 30 years' experience including the care of elderly patients in rest homes), advised that in a rest home setting, the key to good care is "team work, collaboration, and regular communication". As the clinical nurse manager, RN Mrs E was responsible for maintaining close liaison with referrers (which includes GPs) and for ensuring that there were systems in place to keep family members fully informed of any issues relating to a resident's clinical care. In my view, there were gaps in RN Mrs E's communication with Mrs B and in the documentation of any subsequent communication nursing staff may have had with Dr D over the remainder of 2007. Although I have not made a breach finding of Right 6(1) against RN Mrs E, I recommend that she reflect on her communication, and how it could be improved. I note that RN Mrs E has since taken steps to ensure that nursing staff keep a resident's family informed of his/her progress, and she has offered to be the key liaison person in some instances. She also organises and co-ordinates all multi-disciplinary team meetings that families participate in.

Having reflected further on her communication, RN Mrs E has acknowledged the importance of keeping residents' families closely informed of their developments, and involving them in the major decision-making process. This is an appropriate response.

Opinion: Breach — The rest home

Although I have found RN Mrs E in breach of the Code for some aspects of her care, in my view, her employer must share responsibility for the failings.

Clearly, there were a number of gaps and issues in the running of the rest home after the new company assumed ownership, which impacted on the care provided to Mr C, and for which the new owner is responsible.

I acknowledge that the new owner took over the rest home under difficult circumstances, and the ensuing months were a teething period for all involved as the new owner sought to introduce its own policies and procedures, and to familiarise staff with them. There was also a need to assess staff competency levels and to prepare for the certification audits required by the funding District Health Board and the Ministry of Health. That, however, does not excuse the owner from its duty to

ensure first and foremost that residents continued to be well cared for whilst changes were being implemented and to support staff in key management positions during the transition period. Taking on a rest home is not like any other business. Along with the buildings and staff, come vulnerable residents for whom the facility is "home".

Standard of care

The illness of Ms F and protracted appointment of a new permanent facility manager resulted in RN Mrs E functioning in a dual management role for an extended period during the first year of her employment at the rest home and particularly during the busy lead-up to the first audit in August and during other transitional activities.

The rest home has accepted that there was a failure in the delivery of good clinical care to Mr C in its facility. However, RN Mrs E and the rest home differ in their views about whether RN Mrs E was adequately supported. According to RN Mrs E, "[The rest home] did not do enough to support [her], in carrying out two full time jobs for an extended period".

In contrast, while the rest home acknowledged there were gaps in the support and assistance for RN Mrs E, it advised that the period she was unsupported was "significantly shorter" than previously reported.[23] This was because a relieving facility manager was appointed to assist RN Mrs E between mid-August 2007 and mid-January 2008.

Regardless of the different views, it is clear that RN Mrs E was stretched beyond her capacity having to juggle both her clinical role and additional responsibilities at times during the transition period. I share my advisor's view that the rest home failed to adequately support and monitor Mrs E during this period.

In another recent rest home opinion,[24] I highlighted the responsibility of rest home owners to support a clinical nurse manager when a new facility is opened. I stressed the need for particular care and attention in these circumstances. In my view, similar concerns arise here. The new owner had just taken over this facility, the facility manager had health problems leading to 15 full days off work in June and July 2007, and the rest home left it to RN Mrs E to handle the two roles until the relief manager was brought in. They assumed RN Mrs E had the experience to cope.

Furthermore, it appears that following the roll-out of policies and procedures, and the introduction of new documentation, there was no follow-up with staff on how they were handling and adjusting to the changes. Given that it had been "a very stressful experience for staff to be involved in a business that was potentially to close and was then sold", such follow-up with ongoing monitoring would have enabled the rest

[23] Based on the information originally provided, it appeared that RN Mrs E had functioned in a dual management role for the first 10 months of her employment until a permanent facility manager was appointed on 14 January 2008.

[24] 07HDC17647 (available from www.hdc.org.nz).

home to identify issues and concerns at an earlier stage, and to take steps to address them. In addition, it would also have been good practice if the rest home had formulated a management plan to deal with any resistance by staff to the changes. There is no evidence that any of this occurred.

My expert advised that the rest home had a responsibility to:

- ensure all staff have an appropriate level of skill and knowledge to complete allocated positions of responsibility
- smooth transition to new policies, procedures and other changes implemented
- support staff in key positions during takeover phase
- ensure clients continue to be well cared for whilst changes are being implemented.

I consider that the rest home did not fulfil its responsibility adequately.

Documentation

My expert, Ms Rowe, advised that the forms used to document Mr C's care were appropriate. Her comments are supported by Dr Carey-Smith, who commented that "protocols, assessment tools, and care plans appear evidenced based and were applied appropriately in this case". What was of concern was "the lack of knowledge and skill on how to adequately complete the documentation". While it is the role of the clinical nurse manager to guide staff in this respect, I accept that it was difficult for RN Mrs E to monitor and supervise staff adequately owing to the competing demands on her time. In my view, the rest home must also bear some responsibility for this.

Conclusion

I conclude that the rest home did not take adequate steps to support Mrs E and her staff, and ensure that Mr C was provided with services with reasonable care and skill. In my view, the rest home breached Right 4(1) of the Code. I am guided in this respect by my expert nurse, who was asked to advise on the standard of nursing care provided by RN Mrs E and the rest home. I acknowledge that Ms Rowe's opinion differs from that of expert general practitioner Dr Carey-Smith, who commented that overall, the rest home provided a "high standard" of care. However, it is appropriate to take expert advice from a peer (in this case a nursing advisor with extensive aged care experience including clinical nurse management), and I therefore prefer Ms Rowe's advice in relation to the nursing care provided to Mr C. I also note that the rest home has accepted that there was a failure in the delivery of good care to Mr C.

Opinion: No breach — Dr D

Dr D is a vocationally registered general practitioner with a special interest in geriatrics. He was the doctor caring for Mr C at the rest home and he had a long

experience in managing elderly patients, including those with Parkinson's disease and decubitus ulcers.

My expert, Dr Carey-Smith, advised that in most respects, Dr D's care of Mr C was satisfactory, including his record-keeping. On admission to the rest home, Mr C was appropriately assessed by Dr D, who made brief notes and listed Mr C's medical problems and current medication. Subsequently, Dr D saw Mr C monthly (in accordance with the rest home's arrangement with the visiting GP) with additional consultations for problems such as skin rashes, ear wax, falls and urinary problems. On some occasions, there were discussions and agreed care decisions with Mr C and his family. (For example, discussion with Mr C about his walking on 2 November 2006, and a decision in association with staff and family to arrange private physiotherapy on 1 March 2008.) Medication was appropriately ordered (for example, the adjustment of therapy on 22 March 2007 for Parkinson's disease to improve Mr C's mobility).

In light of Dr D's background in caring for the elderly, Dr Carey-Smith stated that he would also be experienced at assessing the benefits of any specialist referral. My expert pointed out that the scarcity of specialist resources means that "they have to be used sparingly". In relation to Mr C, Dr Carey-Smith did not consider that Dr D needed to seek input from a gerontologist or any other specialists.

Dr Carey-Smith advised that it was reasonable for Dr D to adopt a palliative approach to Mr C's care. The initial pressure area and general management of Mr C in 2007 was "appropriately conservative, focusing on preventing decline, encouraging mobility and standard pressure area care", which resulted in some healing in his right hip ulcer despite Mr C's overall gradual decline. By January 2008, Mr C had deteriorated further both physically and mentally, and required "an overall palliative approach". Healing of his pressure areas at this stage was "most unlikely" regardless of any intervention initiated. In reality, admission to hospital and surgical intervention would likely have caused Mr C "more distress and disruption" compared to the ulcers themselves since the notes from the rest home indicated that Mr C was comfortable and largely pain-free. Dr Carey-Smith commented that whilst referral to hospital was an option, it was "certainly not necessary" and was "unlikely to have made any difference to the final outcome". In any case, Dr Carey-Smith noted that the hospital also adopted a palliative approach in managing Mr C following the debridement procedure (on 15 March 2008). It is unfortunate that prior to referring Mr C to hospital, the gerontology nurse omitted to consult Dr D, who could have provided useful information about other aspects of Mr C's management.

Although I am largely satisfied with Dr D's care, Dr Carey-Smith identified two areas where Dr D's management of Mr C could have been better. Following Dr D's first reference to Mr C's pressure ulcers in his notes of 22 May 2007, Dr D did not comment on them again when he reviewed Mr C over the remainder of 2007. Dr Carey-Smith was "mildly critical" of this, and considered that Dr D should have asked

nursing staff about the condition of Mr C's ulcers and reviewed them again subsequently, given his earlier involvement.

Secondly, Dr Carey-Smith was also mildly disapproving of the lack of direct information from Dr D (and his locum GP) to Mrs B in early 2008. It was apparent that Mr C was deteriorating, and Mrs B needed to be told. Understandably, Mr C's family subsequently associated his increased pressure ulcers in 2008 with a lack of care by Dr D and nursing staff at the rest home. Had Dr D ensured that Mr C's family were made aware (in late January/early February 2008) of his decline, they could have discussed possible management options, and accepted Dr D's decision to adopt a palliative and non-interventionist approach. Additionally, Mrs B could have updated her sister accordingly, and prepared her emotionally to face the decline in her father's condition when she visited him in March 2008. Instead, the lack of discussion from Dr D meant that by the time Mrs A saw her father, it was difficult for Dr D to convince Mrs A that her father's condition was reflective of an elderly man who was on the decline, and that it was appropriate to manage him conservatively.

Having carefully considered the above, my view is that these criticisms do not justify a finding that Dr D breached the Code in his care of Mr C. The criticisms certainly identify areas where the care could have been better, but my expert regards these omissions as minor; Dr D has accepted the criticisms, changed his practice, and he has provided a written apology to the family.

Actions taken

Both RN Mrs E and the rest home have outlined significant action that has been taken since the time of these events, to improve care at the rest home. These are outlined earlier in the report.

Recommendations

RN Mrs E
I recommend that RN Mrs E:

- provide a written apology to Mr C's family for her breach of the Code. The apology is to be forwarded to HDC by **3 April 2009** for sending to Mrs B.

The rest home owner
I recommend that the rest home owner:

- provide a written apology to Mr C's family for its breach of the Code. The apology is to be forwarded to HDC by **3 April 2009** for sending to Mrs B.

Follow-up actions

- A copy of this report will be sent to the following parties:

  — The Medical Council of New Zealand and the Nursing Council of New Zealand, for their information.

  — HealthCERT (Ministry of Health) and the District Health Board, for consideration of whether an issues-based audit is warranted to independently verify that appropriate changes have occurred.

- A copy of this report, with details identifying the parties removed except the experts who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, the New Zealand Nurses Organisation, HealthCare Providers New Zealand, and the Association of Residential Care Homes, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

Independent advice to Commissioner — Nurse

The following expert advice was obtained from registered nurse Wendy Rowe.

> "I have been asked to provide an opinion to the Commissioner on case number 08/04291. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am a registered nurse with 23 years of nursing experience. I spent the first 15 years of my career working in a hospital environment in a variety of settings, mainly medical and rehabilitation. I then worked for seven years in the private sector primarily in the aged care arena. I now work as a Senior Academic staff member at a polytechnic and as a casual registered nurse for an agency. I have a Bachelor of Nursing, a Master of Arts and a Certificate in Adult Teaching and Education.
>
> **Expert Advice Required**
>
> Please comment generally on the standard of care provided to [Mr C] by:
>
> (a) RN [Mrs E]
> (b) [The rest home].
>
> *If not covered above, please answer the following questions and include reasons for your view*:
>
> 1. Please advise on the appropriateness of RN [Mrs E] and [the rest home's] care and management of [Mr C's] decubitus ulcers. (*If applicable*) What additional measures should RN [Mrs E] and/or [the rest home] have taken to maintain [Mr C's] skin integrity?
> 2. Please comment on the management of [Mr C's] nutrition including whether he should have been referred to a dietician.
> 3. Please comment on the adequacy of the information provided to [Mr C] and [Mrs B] (Enduring Power of Attorney) by:
>   (a) RN [Mrs E]
>   (b) [The rest home].
> 4. (*If not answered above*) Did RN [Mrs E] keep [Mr C's] EPOA adequately informed about his condition?
> 5. Please comment on the standard of documentation by:
>   (a) RN [Mrs E]
>   (b) [The rest home].
> 6. Please comment on the responsibilities of a new rest home owner when they take over an existing facility.
> 7. Please comment on the changes that RN [Mrs E] and [the rest home] have made since the events in question. In your view, have the concerns about

[Mr C's] care been adequately addressed?

8. (*If applicable*) Please outline any recommendations you may have to address the concerns in this case.

   If, in answering any of the above questions, you believe that RN [Mrs E] and/or [the rest home] did not provide an ppropriate standard of care, please indicate the severity of their departure from that standard.

   To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

9. Are there any aspects of the care provided by RN [Mrs E] and [the rest home] that you consider warrant additional comment?

Supporting Information

- Complaint dated 16 March 2008 with supporting statement, marked A (Pages 1–6).
- Notification letter to RN [Mrs E], marked B (Pages 7–9).
- RN [Mrs E's] response with supporting documents, marked C (Pages 10–28).
- Letter to RN [Mrs E] amending period of investigation, marked D (Page 29).
- Notification letter to [the rest home], marked E (Pages 30–31).
- Information from [the rest home], marked F (Pages 32–47).
- Letter to [the rest home] amending period of investigation, marked G (Pages 48–49).
- Information from GP [Dr D], marked H (Pages 50–60).
- [Mr C's] Support Needs Assessment and discharge information from [the] Hospital in October 2006, marked I (Pages 61–68).
- [Mr C's] nursing records from [the rest home] marked J (Pages 69–430).
  - Admission records (Pages 69–96).
  - Care Plan (Pages 109–122).
  - Progress notes (Pages 151–233).
  - Medication records (Pages 235–240).
  - Weight records (Pages 241–243).
  - Nutrition records (Pages 244–246).
  - Fluid balance records (Pages 247–266).
  - Wound management records (Pages 30–402).
  - Turn charts (Pages 403–408).

- [Mr C's] medical records from [the rest home], marked K (Pages 431–488).
- Referral letter from gerontology nurse dated 10 March 2008, marked L (Pages 489–490).
- Extracts of clinical records from [the] DHB, marked M (Pages 491–494).

[At this point, Ms Rowe includes a précis of the background of the case. This has been omitted for the purpose of brevity.]

RN [Mrs E]

Standard of care provided to [Mr C]

- Did not directly care for client on a daily basis.
- Responsible for the standard of care and the ongoing monitoring of the care provided by the staff.
- Responsibilities included competencies of RNs which she indicates were up to date.
- No review of documentation or clinical practice was undertaken during [Mr C's] deterioration of his ulcers.
- Refers at one stage in her correspondence to ulcers as 'sores' (p 105 & 106). This is a lay person's term and would not be used by a RN normally to describe a major wound.
- The GP is not responsible for the care being delivered to the clients by the staff as this is the responsibility of the CNM.
- Wound care education is indicated to have taken place before the complaint was made about [Mr C's] care. However, there is no evidence that the RNs had adequate knowledge to care for these ulcers.

Care and Management of [Mr C's] decubitus ulcers

- CNM is responsible for the standard of care including wound care management of all RNs. This includes a comprehensive assessment, ongoing plan of care, appropriate documentation to show evidence of ongoing monitoring of wounds which includes descriptions of significant changes in the progress notes. None of these are evidence in the documentation provided.
- Inconsistencies in the daily documentation by RNs were evidenced.
- Poor choice of product and no knowledge of wound healing is evidenced by inappropriate completion of forms used.

- Second ulcer not clearly identifiable in progress notes.
- Both ulcers were not cared for appropriately by staff.

Additional measures RN [Mrs E] should have taken to maintain [Mr C's] skin integrity

- Evidence of pressure relieving air mattress,[25] two hourly turns,[26] hoist use for transfers and daily dressings.
- Other complications included incontinence and poor nutritional intake at times.
- Supplements prescribed and if given regularly would support good skin integrity.
- Staff should have been encouraged to maintain a level of mobility as the Physiotherapist visited and was able to mobilise the client. If the staff had mobilised the client on a daily basis skin integrity may have improved instead of using hoist or wheelchair always
- Earlier referral to a wound care specialist nurse by CNM may have improved skin integrity also.

[The rest home]

Standard of care provided to [Mr C]

- Did not monitor/support adequately CNM whilst FM absent or working on audits/quality.[27]
- No input/support from Quality Assurance Coordinator evidence during time of event although three[28] audits were completed.[29]

[25] Although the exact date a pressure relief mattress was applied is unclear, the rest home states that there is evidence the mattress was re-set by the occupational therapist on 24 May 2007.

[26] There is documentation that 2–3 hourly turns were being carried out although turns were less frequent at times.

[27] The expert nursing advice from Ms Rowe was provided prior to the provisional report dated 23 January 2009. In response to the provisional report, the rest home clarified that a relieving facility manager worked alongside RN Mrs E from 13 August 2007 to 18 January 2008 until a permanent facility manager was appointed on 14 January 2008.

[28] In response to the provisional report, the rest home clarified that they underwent two rather than three audits. The first audit on 1 August 2007 was conducted by the DHB as the funding authority, while the second audit on 18 September 2007 was a Health & Disability Services Certification audit.

[29] The rest home stated that "unless specifically requested either by the managers in the facility or by the operations manager, it is not the role of the Quality Assurance Coordinator to provide input/support".

- Follow up on the introduction of new policies, procedures and documentation would have been of benefit to staff with ongoing monitoring.
- No management plan identified to manage resistance to change among staff.[30]

Adequacy of the information provided to [Mr C] and [Mrs B] (Enduring Power of Attorney)

- Appropriate level provided as documented in progress notes and on forms.
- Evidence of response to complaint appropriate.

Standard of documentation

- As already noted there was a poor standard of overall documentation at this facility during this event.
- There were no problems identified with the forms used to document. These are of an appropriate standard. Lack of knowledge and skill on how to adequately complete the documentation is evidenced. This is the responsibility of the CNM and RNs.
- Ongoing monitoring of the documentation is absent.

Responsibilities of a new rest home owner when they take over an existing facility

- Ensure all staff have an appropriate level of skill and knowledge to complete allocated positions of responsibility.
- Smooth transition to new policies, procedures and other changes implemented.
- Support staff in key positions during take over phase.
- Ensure clients continue to be well cared for whilst changes are being implemented.

Changes [the rest home] has made since the event

- Comprehensive investigation completed following this event with positive outcomes.

[30] The rest home clarified that in response to the family's complaint, an internal review was carried out over March–April 2008. As discussed above, one of the rest home's most senior nurses worked alongside RN Mrs E and nursing staff. It was during this period that issues regarding resistance to change among staff were formally raised and strategies discussed.

- Support given to CNM and FM that is ongoing.
- Indication of education of RNs pertaining to wound management, documentation and policies.
- Processes reviewed for referral to speciality providers.

Recommendations

- Close monitoring of standards of care at this facility.
- Monitoring and support of CNM.
- Regular review of documentation.
- Ensure six monthly reviews on all clients completed with client present and EPOA/ NOK [next of kin] family members as appropriate.
- Up skilling of CNM and RN's clinical skills to ensure they continue to meet Nursing Council Competencies.
- [The rest home] did not provide an appropriate standard of care for [Mr C]. The providers' peers would view the conduct with moderate disapproval.

Additional Overall comments

I acknowledge the difficulty of caring for a client with complex issues. Both RN [Mrs E] and [the rest home] need to take responsibility for the overall care provided to [Mr C] and the poor management of his wounds.

The registered nurses working in this facility also need to take responsibility for their own practice. They also have a duty of care to ensure that they are up to date and accountable for their own individual practice on a daily basis. They are the ones who direct and delegate the care staff to carry out personal care for clients. The registered nurses must take ownership of the need for ongoing knowledge acquisition to ensure client safety is maintained. There was nothing wrong with the forms used at this facility to capture care episodes; it was the registered nurses' inability to adequately complete this documentation to an appropriate level that was evidenced during this investigation. The Clinical Nurse Manager lacked insight into the level of care being provided."

Appendix B

Independent advice to Commissioner — General Practitioner

The following advice was provided by Dr Keith Carey-Smith, a vocationally registered general practitioner:

> "**Introduction**
> In order to provide an opinion to the Commissioner on case number 08/04291, I have read and agree to follow the Commissioner's Guidelines.
>
> My opinion is based on my training in general medicine, and general practice, and my experience and ongoing education as a general practitioner in Taranaki for over 30 years. This includes experience in the management of elderly patients in rest homes. In addition I am a RNZCGP Cornerstone Assessor and am also employed part time as GP Liaison for the Taranaki DHB provider arm. My qualifications are FRNZCGP, Dip Obstetrics (NZ) and DA (UK). I have no conflict of interest in relation to this case."

[At this point, Dr Carey-Smith sets out the complaint and précis provided by HDC, which has been omitted for the purpose of brevity.]

> **"Documents and records reviewed**
>
> 1. Complaint dated 16 March 2008 with supporting statement, marked A (Pages 1–6).
> 2. HDC letter of 2 April 2008 seeking a response from [Dr D], marked B (Page 7).
> 3. Initial response from [Dr D], marked C (Pages 8–11).
> 4. HDC notification letter to [Dr D], marked D (Pages 12–14).
> 5. [Dr D's] response to notification, marked E (Pages 15–21).
> 6. [Mr C's] Support Needs Assessment and discharge information from [the] Hospital in October 2006, marked F (Pages 22–28).
> 7. [Mr C's] medical records from the rest home, marked G (Pages 30–50).
> 8. Information from Clinical Nurse Manager, RN [Mrs E], marked H (Pages 51–58).
> 9. Information from [the rest home], marked I (Pages 59–67).
> 10. [Mr C's] nursing records from the rest home, marked J1–J6 (Pages 68–299).
>   a. Admission records, marked J1 (Pages 68–94).
>   b. Care Plan, marked J2 (Pages 95–107).
>   c. Progress notes, marked J3 (Pages 108–190).
>   d. Medication records, marked J4 (Pages 191–196).

e. Weight records, marked J5 (Pages 197–199).
f. Wound management records, marked J6 (Pages 200–299).

11. Referral letter from gerontology nurse dated 10 March 2008, marked K (Pages 300–301).

12. Extracts of clinical records from [the] DHB, marked L (Pages 302–307).

Expert advice requested:

[At this point, Dr Carey-Smith sets out the questions put to him by HDC, which have been omitted as they are repeated within the body of his report.]

General comments:

The background (above) provided by the HDC well summarises the sequence of events in this case. The records and other documentation supplied provide adequate information to assess the clinical care provided by [Dr D] and the rest home rest home over the period in question.

In addition I would make the following general comments:

- The documentation provided by the rest home (renamed [the rest home], but referred to in this report as 'the rest home') indicates to me an overall high standard of care and excellent recording systems at the institution. Protocols, assessment tools, and care plans appear evidence based and were applied appropriately in this case.

- In managing a debilitated elderly patient, a balance needs to be struck between conservative care and relief of distress, and active intervention in an attempt to reverse or cure intercurrent conditions. In the rest home situation relatives are usually willing to delegate decision making to clinical staff, but should always be kept informed. With more major issues (such as surgical procedures), the decision to intervene or not involves discussion and agreement between the various parties involved: patient (if competent), relatives, nursing and medical staff, and specialist clinicians when involved. In most cases an agreed decision can then be reached. However sometimes there is disagreement, or some relatives may have varying viewpoints, or may not be aware of all the factors involved. The key to good care is team work, collaboration, and regular communication.

- Standard medical etiquette when a patient is referred by a general practitioner for a specialist opinion would include discussing management options with the primary clinician with overall responsibility for management of the patient. The referral in this case was primarily to seek assistance in ulcer nursing management. The specialist nurse involved made a decision to arrange hospital admission without consultation with the patient's GP, and with limited knowledge of the wider aspects of [Mr C's] condition. If such a consultation had occurred, in my view a different

outcome, with less disruption and distress for the patient (and family), might have ensued. This case therefore supports the accepted ideal practice, that of continuing involvement by the primary physician during the end-of-life period.

OPINION

1. General comments on the standard of care provided to [Mr C] by [Dr D].

Records indicate that over the period in question (October 2006 to March 2008) [Mr C] had multiple medical problems and was becoming increasing debilitated, deteriorating both physically (mobility, self-care, Parkinson's disease, postural hypotension) and mentally (cognitive impairment, depression). the rest home appeared to take all measures to prevent or ameliorate this deterioration (eg physiotherapy, occupational therapy, skin care). Nursing and medical records document episodes of deterioration and improvement (eg December 2006, May 2007, October 2007), but overall [Mr C] gradually declined in health.

[Dr D's] records indicate that he appropriately assessed [Mr C] on his admission to the rest home on 17/10/06. His multiple problems and current medication were listed. A brief examination was recorded. [Mr C] was subsequently seen and examined regularly on a monthly basis, with additional consultations for inter-current problems such as skin rashes, ear wax, urinary problems, and falls. Several entries indicate discussions and agreed care decisions with the patient or relatives (eg. discussion with [Mr C] about his walking on 2/11/06; decision in association with staff and family to arrange private physiotherapy on 1/3/08). Management and medication was ordered appropriately (eg adjustment of therapy for Parkinson's disease on 22/3/07 to improve mobility). I consider the standard of care indicated by these records to be appropriate and of a high standard.

The first mention of a pressure area on the right hip in the nursing notes was on 22/4/07 (p.134). This was dressed, appropriate pressure relieving measures taken, and the family informed. There is no mention of this in the medical notes of 26/4/07 (when seen by [Dr D] for possible scabies), and early May (routine review), suggesting that staff were not overtly concerned and did not feel additional medical input was indicated. There would be no reason for [Dr D] to examine the relevant areas at these visits. However on 22//5/07 [Dr D] was asked to see [Mr C] because he was unwell, with reduced food/fluid intake and responsiveness. The hip pressure ulcer was noted for the first time, observed to be infected, thought to be causing the deterioration, and appropriate antibiotic treatment and subcutaneous fluids were prescribed. [Dr D] reviewed [Mr C] two days later and recorded improvement. This care is considered to be of appropriate standard.

There is no further mention of pressure ulcers at the regular and extra visits over the following six months. Pressure area management is normally considered a nursing task, with medical involvement only if nursing measures are unsuccessful or intervention required. The lack of mention in the medical notes suggests that nursing staff had no concerns about the management of the pressure areas. It would be appropriate however for [Dr D] to enquire of nursing staff about the current status of the ulcers (since he had previously been involved in treating them), and to occasionally examine the area, but there is no record of this having been done. [Dr D] states in his letter that "I understand that the wound did improve although did not heal completely", and his comments in the second letter suggest that this statement was made in retrospect (having viewed nursing records indicating ulcer improvement and healing in June/July 2007), implying that at the time he neglected to enquire or had forgotten about the ulcer. However he also states in the second letter that "I am sure…that I would have periodically asked about the wound, or the nurses would have been mentioned to me as part of the monthly review process". Either way, I would consider this lapse to be a minor departure from standard practice, viewed with mild disapproval.

The records indicate continuing regular GP oversight for the rest of 2007. Appropriate assessment, intervention and discussion with family members for inter-current illness and episodes of deterioration (eg 6/11/07) were recorded. The next mention of right hip pressure area was by a deputising doctor on 10/1/08. The ulcer was noted to be deep and non-healing. Appropriate skin pressure management including antibiotics were prescribed. The nursing notes record the deteriorating ulcer late December, but clearly it was not brought to the attention of a doctor until 10 January. [Dr D] was away and first saw [Mr C] with the ulcer relapse on 4/2/08 at his usual monthly visit, and continued the management already commenced. The ulcers were at that stage noted to be bilateral. Further deterioration was noted a week later on 12/2/08, and ulcer measurements were recorded. Management was discussed and adjusted. In my judgement these measures were appropriate, and referral not indicated primarily because of [Mr C's] overall condition and absence of practicable alternative management options. The issue of surgical intervention was not raised or mentioned in the notes, presumably because it was not considered to be an option at this stage. From the evidence supplied, I agree with [Dr D] that surgical intervention was not appropriate in this situation (see also below).

However, there is no mention of discussion about [Mr C's] condition with the relatives at this point (see para 5 below). [Dr D] may have been informed (or may have assumed) that rest home staff were keeping relatives informed. In fact nursing notes indicate that discussion took place (eg on 10/2/08: "visited by daughter. She said she is happy with the care"). [Mr C] was having regular dressings to the ulcers, and it is unlikely that his daughter was not aware of the pressure ulcers.

A second daughter (Mrs A) arrived from Australia late February, was distressed by the state of the ulcer, and met with [Dr D] on 4/3/08. After discussion a referral to the hospital wound care specialist nurse was agreed. [The]Gerontology nurse specialist saw [Mr C] on 10/3/08 and arranged admission to hospital, apparently because she was concerned about underlying osteomyelitis (bone infection). There was no consultation with [Dr D] prior to admission under the geriatric service. [Dr D] had no further clinical contact with [Mr C], who, after surgical ulcer debridement on 15/3/08, died [a few weeks later] of sepsis, chest infection and general debility.

Answers to further questions and reasons for view (if not covered above):

2. Comments on the appropriateness of [Dr D's] decision to adopt a palliative approach in managing [Mr C].

The initial pressure area and general management (2007) was appropriately conservative, focussing on preventing decline, encouraging mobility, and standard pressure area care. This resulted in partial or complete ulcer healing, despite overall gradual deterioration in [Mr C's] condition.

By January 2008 [Mr C] had deteriorated further both physically and mentally. An overall palliative approach was clearly indicated, which extended to the management of his pressure ulcers. Healing at that stage was most unlikely, with or without debridement or grafting. Admission and surgical intervention was likely to have caused more distress and disruption to [Mr C] than the ulcers themselves (reports all indicate that he was comfortable and largely pain-free). I therefore consider surgical intervention to have been inappropriate, and a continued 'palliative' approach to be entirely justified. A palliative approach was also adopted by the hospital following the initial debridement procedure.

3. Advise whether [Dr D] should have sought input from a gerontologist and/or any other specialists in managing [Mr C's] care.

Some general practitioners would refer complex patients such as [Mr C] for a geriatric opinion to be sure management was appropriate (eg. therapy for Parkinson's disease). However [Dr D] has long experience in managing elderly patients, including Parkinson's disease and decubitus ulcers. He would also be experienced at assessing the benefit (if any) to be gained from consultation with a geriatrician or other specialist (scarcity of such specialist resources mean that they need to be used sparingly). Surgical referral for any surgical condition is only appropriate if the condition can be helped by surgical management, and if the patient's health status allows a surgical procedure. In the case of decubitus ulcers, indications for referral would be a patient with an ulcer likely to heal (eg. due to temporary immobilisation), and with otherwise good physical, mental and nutritional status. In some cases referral can be

deleterious to the patient's overall care, resulting in inappropriate intervention, and other risks associated with hospital admission.

Another experienced doctor ([Dr D's] deputy) saw [Mr C] at the time the ulcers had deteriorated. He also did not consider specialist referral necessary.

In my opinion, in this case referral was an option, but certainly not necessary, unlikely to have made any difference to the final outcome, and if inappropriately referred, could have been detrimental. The referral eventually made is unlikely to have affected the final outcome.

4. Comments on the communication between [Dr D] and nursing staff at the rest home, including whether nursing staff were appropriately guided.

As mentioned (para 1), either nursing staff failed to mention the progress of the ulcers between May 2007 and January 2008, or the issue was discussed but the discussion not recorded in nursing or medical notes. Ideally, earlier notification of the ulcer deterioration to [Dr D] or his deputy in late December 2007 would have been appropriate. When the doctors became aware of the ulcer deterioration in mid January/early February, it would have been appropriate to ensure that the relatives had been informed of the situation. There was not evidence that they did this, although it would appear from the nursing notes that the relatives were aware. All this suggests a possible deficit in communication between the nursing staff and doctors. There is no evidence of a lack of guidance from [Dr D] to the nursing staff once he became aware of the situation.

5. Comments on the adequacy of information provided by [Dr D] to [Mr C] and [Mrs B] (Enduring Power of Attorney).

As noted above (para 1), medical notes indicate discussion with [Mr C] at an earlier stage before dementia had progressed. At the later stages there is evidence that his cognition deteriorated to a point that informed decision making by him became impossible.

Normal practice with rest home patients, where relatives are not usually present when the doctor visits, is for nursing staff to carry out most communication with relatives, usually the ones that routinely visit the patient. [Dr D] would assume that this was occurring, and there is no evidence that there was any deficit in such communication with his daughter [Mrs B] (who had Power of Attorney). [Dr D] readily discussed management with family when requested (eg. the meeting with daughter [Mrs A] on 4/3/08).

However, normal practice would be for the doctor to take the initiative in discussing more concerning or life-threatening issues with relevant family members (and the patient if capable of understanding), even if the nursing staff

had already talked to them. There was no particular concern necessitating such discussion prior to January 2008, but at that stage in my opinion [Dr D] (or his deputy) should have directly informed [Mrs B] about the deterioration. This would have allowed discussion about possible intervention, referral or hospital admission. Thus an additional deficit I would view with mild disapproval is the apparent failure to ensure family members were aware in late January/early February 2008 of [Mr C's] deteriorating condition, and to give them the opportunity to discuss management options.

6. Comments on [Dr D's] standard of documentation.

I consider [Dr D's] medical notes to be thorough and of satisfactory standard throughout the period in question.

7. Comments on the changes [Dr D] has made since the events in question. Have the concerns about [Mr C's] medical care been adequately addressed?

[Dr D] states that he has lowered his threshold for referral of pressure sores, and that he has become aware that the hospital now providing services for his patients is now prepared to consider cases for surgical debridement when appropriate. This appears to be an appropriate response.

8. (*If applicable*) Outline of any recommendations to address the concerns in this case.

The following additional recommendations could assist in avoiding future similar complaints:

- Ensuring all aspects of a patient's management are discussed and documented at each regular monthly review.

- A lower threshold to directly notify (and discuss with) relatives (and/or the patient) any significant or life-threatening complications.

- Improved interdisciplinary collaboration. In particular, the rest home should ensure that the patient's general practitioner is involved in (or at least informed of) any major changes to the management plan suggested by other health professionals.

9. Aspects of the care provided by [Dr D] warranting additional comment

No other significant issues need additional comment.

CONCLUSION

[Mr C's] case illustrates the difficulties in managing elderly patients with multiple problems near their life's end. The inevitable decline can only be temporarily delayed by nursing and other preventive measures, and complications such as pressure ulcers can develop despite all such measures. I consider the care provided jointly to [Mr C] by [Dr D] and the rest home overall to be of a high standard. I do not think that any other measures could have been taken to prevent or heal the ulcers, or to delay the final decline in condition. More importantly, I consider that care provided was appropriately directed towards ensuring minimum distress and maximum comfort for [Mr C].

It was clearly very distressing for [Mrs A] to view the unpleasant ulcers that had developed, and her reaction is understandable. Prior knowledge of the development of these ulcers and [Mr C's] general deterioration would have better prepared her, and I view with mild disapproval the lack of direct information given by [Dr D] and his deputy to the family in early 2008 when this became apparent. I am also mildly critical of the absence of evidence that [Dr D] enquired about or examined the pressure areas after problems initially developed in May 2007. In all other respects I consider care provided by [Dr D] to have been of a satisfactory standard."

Appendix C

14/4/08

PROCESS FOR REPORTING SKIN INTERGRITY CHANGES(SKIN TEARS,PRESSURE AREAS,OR ANY OTHER WOUNDS)

-All wounds are to be reported as an incident
- Clinical Manager to be notified
- Notify the family
- Notify the GP
-Document in Clinical Notes
-Initiate a wound care plan
-Change care plan as required
-Communicate to all care staff
-ENS to communicate with the RNs
-Pressure areas grade2+ > to be photographed
-Number, type and status reported weekly to the Facility Manager via the Facility Managers report
-Wounds to be reviewed by the Clinical Manager and the Facility Manager on a weekly basis(Wednesdays)

REGISTERED NURSES TO KEEP UP WITH THE SUPPLIES OF ALL DRESSING PRODUCTS CURRENTLY IN USE.MAKE SURE SUPPLIES ARE ORDERED BEFORE IT RUNS OUT SO THAT WE HAVE ENOUGH FOR AFTER HOURS AND THE WEEKENDS.

THANKS