Radius Residential Care Limited

(operating as Radius St Winifred's Hospital)

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC01229)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. Mr A, then aged 70 years, was admitted to respite care at Radius Residential Care Limited's Radius St Winifred's Hospital for 18 days from 24 May 2012 to 12 June 2012.

2. Mr A had multiple co-morbidities, including type II diabetes. Mr A's left leg had been amputated below the knee, and his right foot had two chronic infective ulceration wounds on his big toe and heel. These wounds had been managed in the community by district nurses since 2008. In addition to the two ulceration wounds, Mr A had a skin tear on his right leg.

3. During his time at Radius St Winifred's, Mr A's right foot wounds deteriorated, particularly his right big toe, which became necrotic. In addition, it was suspected that Mr A had a urinary tract infection. Mr A was prescribed antibiotics by his general practitioner, Dr C. Despite evidence of necrosis, the nursing staff at Radius St Winifred's did not request that Dr C review Mr A in person, nor did they inform Dr C of the deterioration of Mr A's wounds.

4. On 14 June 2012, two days following his discharge from Radius St Winifred's, Mr A was admitted to hospital, presenting with gangrene of his right big toe. Mr A's right leg was amputated above the knee on 13 July 2012.

Findings

5. Radius Residential Care Limited did not provide services to Mr A with reasonable care and skill with regard to his assessment on admission, his care planning and wound care, and a lack of adequate assessment and follow-up of his change in health status. Radius Residential Care Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

6. Mr A had a right to have services provided that complied with legal, professional, ethical, and other standards. Radius Residential Care Limited's documentation and communication with Mr A's family did not meet the New Zealand Health and Disability Sector Standards and breached Right 4(2) of the Code.[2]

7. Radius Residential Care Limited's staff failed to communicate effectively with one another and with Dr C to ensure that Mr A received quality and continuity of services. This was a breach of Mr A's right to have co-operation among providers and to ensure quality and continuity of services. Accordingly, Radius Residential Care Limited breached Right 4(5) of the Code.[3]

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[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[3] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

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8. Adverse comment is made about Radius Residential Care Limited's use of wound care products, and about Dr C's documentation.

Complaint and investigation

9. The Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A, by Radius St Winifred's Hospital. The following issue was identified for investigation:

   - *Whether appropriate treatment and care was provided by Radius Residential Care Ltd trading as Radius St Winifred's Hospital to Mr A between 24 May 2012 and 12 June 2012.*

10. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant, Mr A's wife
Radius Residential Care Limited	Provider
RN B	Facility Manager

12. Information was also reviewed from:

Mr and Mrs A's son	
The District Health Board	Provider
Dr C	General practitioner (GP)
RN D	Clinical Nurse Manager

13. Also mentioned in this report are:

A community nursing services provider	
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
EN J	Enrolled nurse
EN K	Enrolled nurse
Dr M	Vascular surgeon

14. Independent expert advice was obtained from Ms Carolyn Evans, a registered nurse with expertise in aged care (**Appendix A**).

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Information gathered during investigation

Mr A

Background

15. At the time of these events Mr A was 70 years old and lived at home with his wife and son. Mr A had a number of health conditions, including chronic renal impairment, pulmonary vascular disease,[4] type II diabetes, diabetic retinopathy,[5] high blood pressure, ischaemic heart disease,[6] and dyslipidaemia.[7] Previously, Mr A had undergone a right leg angioplasty[8] for critical limb ischaemia.[9] In addition, Mr A's left leg had been amputated, and he had suffered with chronic infective ulceration wounds on his right big toe and heel since 2008.

16. Mrs A told HDC that since her husband's strokes a number of years earlier, he continued to be aware of his surroundings and was able to do basic tasks. She explained that he knew that he needed to have dressings on his wounds, but he would not be aware of when his dressings needed to be changed or how frequently. Mr A had difficulty telling one day from another, and would be confused at times.

Wound care prior to admission

17. Since 2008, Mr A's wounds had been managed in the community by district nurses. According to Mrs A, Mr A's wounds had remained stable since district nurses became involved in his care.

18. On 10 April 2012, in a letter to the district nursing service, a vascular surgeon, Dr M, noted that if Mr A's wounds deteriorated he was to be seen "as a matter of urgency", as this could indicate he had blood clots.

19. On 21 May 2012, a district nurse re-dressed Mr A's wounds, recording in the medical notes:

> "[Right] big toe — nil change 100% thick slough.[10] Redressed with [Iodosorb] gauze[11] and Omnifix[12] … [Right] tibial crest x2 leaking serous fluid areas cleaned redressed [I]nadine[13] and gauze … Heel minimal slough redressed with AMD foam[14] and micropore tape.[15] Podiatry felt in place. Pod[iatry] r/v [review] Thurs.

[4] A disorder affecting blood circulation in the lungs.
[5] Damage to the retina caused by diabetes.
[6] Reduced blood supply to the heart.
[7] Abnormal amount of lipids in the blood.
[8] Surgical repair or unblocking of a blood vessel.
[9] A sudden lack of blood flow to a limb.
[10] A layer or mass of dead tissue separated from surrounding living tissue.
[11] Iodosorb gauze is sterile gauze containing iodine.
[12] Omnifix is a latex-free dressing.
[13] Inadine is a non-adherent surgical dressing containing povidone-iodine.
[14] Antimicrobial foam dressing.
[15] Micropore tape is latex-free, hypoallergenic paper tape.

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Rebandaged [T]ubinette[16] + [R]olta soft[17] + crepe. [Left] stump x2 sloughy areas nil dressing in place. Applied [I]nadine gauze + Omnifix."

20. On 24 May 2012, Mr A saw a podiatrist at the Diabetes Centre. The podiatrist noted that both ulceration wounds on Mr A's right foot had a "thin sloughy layer". The podiatrist also noted a new skin tear on Mr A's right leg, and dressed it.

21. Later that day,[18] Mr A was admitted to Radius St Winifred's Hospital (Radius St Winifred's) for 18 days of respite care while his wife went overseas to visit family. Mr A remained at Radius St Winifred's until 12 June 2012.

Radius St Winifred's

22. Radius St Winifred's is owned by Radius Residential Care Limited (Radius). Radius is a specialist health and aged care provider for the elderly and disabled, and has 20 aged care facilities around New Zealand. Radius St Winifred's is an aged care facility that specialises in providing hospital and dementia care. The facility also provides palliative care and respite care.

Staffing

Facility Manager

23. In 2012, during Mr A's stay, RN B, a registered nurse, was the Facility Manager at Radius St Winifred's. RN B had been in her role since 2011, but is no longer employed by Radius.

Clinical Nurse Manager

24. The Clinical Nurse Manager, Registered Nurse (RN) Ms D, began working at Radius St Winifred's as a registered nurse on 4 January 2012. On 16 May 2012, RN D was appointed Clinical Nurse Manager and underwent an orientation and handover period from 16 May 2012 to 22 May 2012. RN D had completed her orientation for the Clinical Nurse Manager position two days prior to Mr A's admission.

Additional staff

25. Radius St Winifred's employs a number of registered nurses, enrolled nurses and healthcare assistants. Radius St Winifred's told HDC that the registered nurses and enrolled nurses in one wing of Radius St Winifred's were responsible for Mr A's care. In total there were six registered nurses, four enrolled nurses, and a number of healthcare assistants who attended to Mr A during his 18-day admission at Radius St Winifred's.

[16] Tubinette is an elasticated tubular support bandage.
[17] Rolta soft is a padded bandage.
[18] Mr A was admitted on either 24 or 25 May 2012. Mrs A told HDC she is certain that her husband was admitted on 25 May 2012, the day before she left to travel overseas. Mrs A thinks that the admission documentation could be incorrectly dated, as initially Radius St Winifred's was going to drop off the forms to her to fill in the day prior to her husband's admission. Radius St Winifred's documentation is inconsistent about the date Mr A was admitted. The first progress note entry is dated 25 May 2012, but the admission documentation is dated 24 May 2012. Radius St Winifred's advised HDC that the date on the first progress note entry is incorrect.

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Policies

26. Radius's policies include the "Assessment, Care Planning & Review Clinical Manual — Policy and Procedure" (the Clinical Manual), the "Clinical Records Policy & Procedure" (the Clinical Records Policy), the "Skin Care Policy & Procedures" (the Skin Care Policy) and the "Wound Care Policy & Procedures" (the Wound Care Policy). Relevant extracts are included below.

27. In relation to care planning, the Clinical Manual states:

- On admission a registered nurse will complete the Initial Assessment/Care plan during the shift on which the client is admitted.
- Short term care plans are to be developed for any acute needs which are likely to be resolved within four weeks such as a UTI,[19] wound care plan, or respiratory infection. They are to be reviewed daily with appropriate documentation of this in the multidisciplinary progress notes.
- Family/whānau are to be consulted and included in care planning for clients at all times.

28. The Clinical Records Policy states:

- Fully integrated multidisciplinary clinical records will be maintained for each client from the point of first contact with the organisation to the end of the service.
- The clinical records will provide an accurate account of care delivered and permit communication among health professionals.
- Clinical records will demonstrate the continuum of service based on an ongoing process of assessment, planning care, setting goals and evaluation.

29. The Skin Care Policy states that the initial care profile (to be completed within eight hours of admission) will identify any immediate risk that a client may have for the breakdown of pressures areas.

30. The Wound Care Policy states:

- A registered nurse will make the initial assessment of a wound and develop a care plan.
- If a registered nurse is concerned about a wound due to delayed healing, pain, or infection, then the wound is to be reviewed by a registered nurse and the care plan altered as necessary and/or appropriate intervention or referral made to a doctor.
- All wounds will be thoroughly assessed and care plan formulated with interventions appropriate for the specific wound and requirements of the client, including documentation of ongoing evaluation and dressing changes.

[19] Urinary tract infection.

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Admission to Radius St Winifred's

Documents from Mrs A

31. On 24 May 2012,[20] Mrs A wrote a note to accompany Mr A on his admission. The note stated:

> "[Mr A] has torn the skin on the front of his right leg today. Rather a mess. The podiatrist has dressed it today but says it needs to be checked tomorrow and redressed. His heel and toe was dressed today. It needs dressing each Monday and Thursday."

32. In her note, Mrs A did not mention the types of dressing that district nurses had been using on the recommendation of Mr A's podiatrist. However, she provided Radius St Winifred's with an open box containing crêpe bandages and latex-free Omnifix dressings, case notes from the most recent dressing done by district nurses (21 May 2012),[21] and case notes by Mr A's podiatrist from that morning.

33. The admitting nurse, RN E, told HDC that Mrs A gave her paperwork that Mrs A thought was relevant to Mr A's care and wound care.

34. In summary, at the time of admission, Mr A had dressings on his right big toe and right heel, and a bandage on his right leg where he had torn the skin. He also had two sloughy areas on his left stump, which were not dressed.

Admission documentation

35. A "Respite/Short Term Assessment, Care & Discharge Plan" (Care Plan) was completed for Mr A on 24 May 2012 by RN E.[22] RN E recorded in Mr A's Care Plan that he had declined mobility, was a diabetic, and was cognitively impaired. She also noted that he required assistance with toileting, personal cleansing and dressing, controlling his body temperature, skin/pressure area care, and safety/mobility. In relation to mobility she noted that Mr A used a manual wheelchair, but she did not record that his left leg had been amputated.

36. There were no special care requirements listed for Mr A's dependent tasks. However, RN E specifically noted in the special care requirements section of the Care Plan that Mr A had a skin tear on his right leg, and that the plan of care was to "check dressing daily, change when strike through". There is no mention of the wounds on Mr A's right big toe, his right heel or his left stump.

37. It is not documented whether Mr A's baseline observations (temperature, blood pressure, pulse, or respirations) were taken. There is also no record of whether skin or pressure risk assessments were conducted. Accordingly, no management plan was developed for Mr A on how to avoid pressure area risks or how to maintain his skin integrity.

[20] See above n 18.
[21] See paragraph 19.
[22] The Care Plan is dated 24 May 2012 on the first page and 25 April 2012 on page four. Radius St Winifred's confirmed that the second date was recorded in error, and should state 24 May 2012.

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38. RN E stated that she did not have time to check Mr A's wounds visually, and provided all the information to a nurse on the afternoon shift to complete the assessment.

39. Enrolled Nurse (EN) Ms J completed a "Wound Assessment & Care Plan" form (Wound Care Plan) for Mr A. The Wound Care Plan is dated 24 May 2012 and appears to relate to Mr A's skin tear ("skin tear" is selected as the wound type) (Wound Care Plan 1). Wound Care Plan 1 also records that the skin tear was to be dressed every second day, with the next dressing due on 26 May 2012. There is no evidence that Wound Care Plan 1 was also to cover Mr A's right toe and heel wounds or his left stump. No Wound Care Plans in relation to those wounds were completed on admission.

40. On 29 May 2012, a "Care Plan Summary" was completed by an enrolled nurse. It is unclear whether this document was reviewed by a registered nurse. The summary recorded that fatty cream was to be applied to dry skin areas daily. No further skin integrity assessment was conducted.

41. Mrs A told HDC that she was not involved in completing the admission documentation and had no input into Mr A's Care Plan. Mrs A was told by Radius St Winifred's that the day before her husband's admission, a form would be dropped off in her mailbox to fill in (it was not). When her husband was admitted, she was told that the form was not given to her because Mr A did not have an activated enduring power of attorney in relation to his personal care & welfare at that stage, and so it was expected that he would be able to fill out the form himself.

Wound care

42. On the second page of Wound Care Plan 1 is a "Wound Review Plan" (Wound Review Plan 1), which was used by staff to record the status of wounds and dressing changes. The form has space at the top to record the date of each assessment, and space at the bottom to record the frequency of the dressing changes and for the assessor to sign. There are nine sections for the assessor to complete. The form requires the assessor to record details in boxes or to select an option from a list and to tick beside it. The nine sections are as follows:

- wound size (assessor to record depth, width and length);
- wound bed (assessor to select pink, red, yellow, or black);
- wound margins (assessor to select intact/healthy, inflamed, rolled, or macerated);
- exudated (assessor to select type of exudation and amount);
- odour (assessor to select none, slight, moderate or heavy);
- pain from wound (assessor to select yes or no and whether pain relief is required);
- wound infection suspected (assessor to select yes or no and whether a swab has been taken);
- evaluation overview (assessor to select unchanged, improved or deteriorated); and
- wound review (assessor to record primary and secondary dressings/products used).

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43. Nursing staff at Radius St Winifred's use separate progress notes to record general nursing notes. The details of Mr A's wound care were sometimes recorded in his Wound Review Plans and sometimes in his progress notes.

44. On 25 May 2012, EN J recorded in the progress notes that she re-dressed the skin tear on Mr A's right leg. This was not recorded on Wound Review Plan 1.

45. Mr A's skin tear was not re-dressed for three days. On 28 May 2012, RN G recorded on Wound Review Plan 1 that she cleaned Mr A's skin tear with Betadine[23] and covered it with Hydrofilm.[24] She also recorded this dressing change in the progress notes. In the progress notes RN G also recorded: "[N]oticed pressure sore [right] heel." RN G did not complete a new Wound Care Plan for Mr A's heel wound but noted it on Wound Care Plan 1, which was completed on admission. RN G did not record the type of dressings to be used, the frequency of dressing changes, or any other details about the care and management of this wound. In relation to the right heel wound, RN G wrote on Wound Review Plan 1 that she cleaned it with Betadine and covered it with gauze and Tegaderm.[25]

46. Mr A's wounds were not re-dressed for four days. On 2 June 2012, an EN recorded on Wound Review Plan 1 that she cleaned Mr A's wounds and re-dressed them with Hydrofilm. She also recorded that she re-dressed Mr A's toe. This was the first time she had sighted the wounds.

47. On 4 June 2012, "undocumented dressing change" is written in the margin of the progress notes. A healthcare assistant recorded in the progress notes: "Enquired about family, and they haven't made contact. RN informed. Also about dressings, no other notable concerns."

48. On 6 June 2012, RN F recorded in the progress notes:

> "[Patient] had pain … right toe wound measured approx 1.5cm x 1cm x 2mm, wound bed is black and necrotic. Wound washed with saline and debrided necrotic tissue. PolyMem[26] on wound and covered with gauze and secured by Omnifix. Wound chart written."

49. The Wound Care Plan (referred to by RN F as a "wound chart") completed by RN F for the toe wound (Wound Care Plan 2) included a Wound Review Plan on the second page (Wound Review Plan 2). RN F recorded that the wound was a pressure sore, and that the primary dressing was to be PolyMem and the secondary dressing gauze. He also recorded that the dressing was to be changed every two days, with the next dressing due on 8 June 2012. There is no evidence of a wound swab being taken to check for infection, and Mr A's GP, Dr C, was not informed. RN F did not record on Wound Review Plan 1 whether or not he reviewed and changed the dressings on Mr A's heel or skin tear.

[23] A broad spectrum antiseptic.
[24] A self-adhesive, transparent, waterproof dressing.
[25] A type of transparent dressing.
[26] A non-adhesive dressing.

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50. Mr A's toe dressing was not changed on 8 June 2012. On 9 June 2012, RN H recorded on Wound Review Plan 1 (which was initially started for Mr A's skin tear): "Cleaned with betadine and covered with polymin. Toe — polymin [PolyMem]. Upper leg hydrofilm plus." It is unclear which wound RN H is referring to, as Mr A did not have a wound on his upper leg. She also recorded that Mr A was on regular paracetamol, and that he did not have pain from his wounds.

51. On Wound Review Plan 1, the box with "granulating (red)" used to describe the wound bed is ticked. It is unclear whether this is referring to the wound bed of Mr A's toe wound, skin tear, or both. The boxes with "sloughy (yellow)" and "necrotic (black)" were ticked, but have been crossed out. RN H also recorded that the wound margins were inflamed. On Wound Review Plan 1 she noted that the wound's exudation[27] was "moderate" (previously low). Wound Review Plan 2 was not completed, but it appears that RN H recorded Mr A's big toe wound review on Wound Review Plan 1. Despite the change in wound status, in particular that at least one wound was inflamed, a wound swab was not taken, and Dr C was not informed.

52. On 11 June 2012, EN K sighted Mr A's wounds for the first time. She did not enter any details into the section for wound size, but recorded that the size was "the same". She recorded on Wound Review Plan 1 that she cleaned and dressed Mr A's wounds. Again, the boxes with "sloughy (yellow)" and "necrotic (black)", which describe the wound bed, were ticked but have been crossed out. EN K told Radius St Winifred's that she is unsure why the boxes were crossed out, but thinks it was because they were ticked in error. She also recorded that the wound margins were inflamed. On Wound Review Plan 2, she recorded (by ticking next to the boxes) that Mr A's right toe wound was "granulating (red)", "sloughy (yellow)" and "necrotic (black)", but the margins were "intact/healthy". She noted that she cleaned the wound with water and Betadine, and covered it with a PolyMem stocking. EN K did not request a review by Dr C or take a wound swab.

53. Later that morning, a healthcare assistant found that Mr A's dressings had come off, and she wrote in the progress notes that she had informed a registered nurse. There is no further entry in the progress notes or in either Wound Plan recording that the dressings were replaced.

Wound dressings

54. As noted above, Mrs A gave the admitting nurse a supply of crêpe bandages and latex-free Omnifix dressings for Mr A's wounds. Mrs A told HDC that her husband was not allergic to latex bandages, but they were not used because they had to be changed more frequently, as his wounds were quite wet.

55. During his stay at Radius St Winifred's, Mr A's wounds were dressed with latex bandages. There is no evidence of any secondary dressings, e.g., crêpe bandages, being used to provide protection for Mr A's toe and heel wounds.

[27] The amount of wound oozing.

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56. Mrs A told HDC: "The bandages I provided were not used and were returned to me upon discharge as plastic bandages were used on [Mr A's] wound throughout his stay." RN B told HDC that the reason the dressings supplied by Mrs A were not used by the staff at Radius St Winifred's was to save these for Mrs A. Instead, they used their own stock of dressings. In separate correspondence, RN B stated:

> "It was not communicated to us that [Mr A] could not have latex dressings and we used our ward stock for his dressings and not his, as his were placed in his cupboard and not seen by the registered staff."

57. Mr A's son told HDC that he visited his father at the end of his first week or the beginning of his second week at Radius St Winifred's and noticed that his father did not have any dressings on his toe, heel or leg wounds. He also noted that his father was wearing sandals, with his feet exposed. Mr A's daughter-in-law also visited Mr A during his stay, and asked staff to re-dress his skin tear, as fluid was leaking from the bandage.

Change in health status

58. On 26 May 2012, an enrolled nurse recorded in the progress notes at 2200: "[Patient] was talking in a confused manner." During the night, RN I recorded that a urine specimen was collected and a dipstick test[28] performed. The dipstick test showed the presence of protein, glucose, and blood. RN I noted:

> "Spec[imen] to be sent to lab … [Please] inform Lab on Monday morning. [Patient] very confused wanting to get out of bed. [Please] refer/inform GP re result of urine dip stick."

59. Radius St Winifred's told HDC: "There is no evidence that the specimen taken on 26 May [2012] was sent to the laboratory and there is no result for that specimen." There is also no record of Dr C being informed. From 27 May 2012 to 29 May 2012, no concerns were recorded in the progress notes.

60. On 30 May 2012, RN E contacted Dr C. Her entry in the progress notes states:

> "Have sent a fax & done follow up phone call in regard to [Mr A]. Proteins ++++ & urine had trace 10 of blood. Explained to Dr as it's first time he has been here and unsure of behaviour. Awaiting reply."

61. On 31 May 2012, RN E recorded in the progress notes that they received a fax back from Dr C requesting that a urine specimen be sent to the laboratory. The results of the urine specimen did not show signs of infection.

62. From 1 June to 6 June 2012 there are no concerns recorded in Mr A's progress notes.

63. On 6 June 2012, RN E recorded in the progress notes:

[28] A basic diagnostic tool used to determine pathological changes in a patient's urine.

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> "Heard [Mr A] dry [retching] this morning at 1130 … Temperature 38.3. Rang Dr's surgery & nurse spoke to [Dr C]. He asked for medication chart & will chart [antibiotics] & something for nausea. Fax sent & waiting for reply."[29]

64. At 12.10pm, RN E administered paracetamol. She did not record whether Mr A was experiencing pain. Mr A's son telephoned, and RN E recorded in the progress notes that she "notified him of [the] situation". Later that day, she contacted Dr C after hours. The details of her discussion are not recorded, but she noted that she had called him. She called Dr C a second time, as Radius St Winifred's was out of stock of the antibiotic he had prescribed. Dr C then charted Augmentin[30] and metoclopramide.[31] Dr C did not record his communications with RN E in his notes.

65. In response to the provisional opinion, Dr C stated that because he was aware of Mr A's chronic ulcer on his right toe, which he had swabbed several times and treated with antibiotics, he felt comfortable about issuing a prescription over the telephone.

66. Dr C was not asked to review Mr A, and told HDC:

> "[Mr A] suffers from peripheral vascular disease and diabetes and he has chronic infective ulcers particularly in his right great toe, hence the reason for antibiotics. In fact the 6 June prescription was repeated on 13 June.
>
> The nurse at St Winifred's Hospital sent me a fax noting a possible urinary tract infection and an MSU[32] was ordered. It must be noted I was never asked to go and see [Mr A] and the antibiotics prescribed and charted were for an ongoing condition which I and the District Nurses knew about."

67. In its response to HDC, Radius St Winifred's told HDC that it was Dr C's decision whether to review Mr A. Radius St Winifred's said that Mr A was started on antibiotics for a chest infection. In a subsequent response, it stated: "It was presumed the antibiotic would help with the wound infection?" Mrs A told HDC that it was never mentioned that the antibiotics were for his wounds. She understood that they were for a chest infection. She said that a nurse told her that the antibiotics he was on would have helped with his wound infection anyway.

68. From 6 June 2012 until his discharge on 12 June 2012, no concerns were recorded in the progress notes except that Mr A had an unsettled night on 10 June 2012.

Discharge

69. On 12 June 2012, Mr A was discharged from Radius St Winifred's. The "Discharge Plan" dated 12 June 2012 noted that Mr A was to return home with his wife, who would support him at home. There is no mention in the Discharge Plan of the worsening of Mr A's right toe wound. Nor is there any mention of Mr A's suspected UTI or the antibiotics he was prescribed.

[29] HDC was not provided with a copy of this fax.
[30] An antibiotic.
[31] An anti-nausea medication.
[32] Midstream specimen of urine.

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Subsequent treatment and amputation

70. The day after Mr A was discharged from Radius St Winifred's (13 June 2012), Mrs A "noticed [her husband's] sock covered in blood, the bandage had come off and his toe nail was literally floating on his toe". Mrs A told HDC that she was shocked at how his wounds had deteriorated during his stay at Radius St Winifred's. That day, Mrs A took Mr A to see Dr C.

71. Mrs A contacted a nurse at Radius St Winifred's to discuss what had happened. Mrs A states that the nurse told her that "that's what happens to diabetics' toes". Mrs A found this remark "unacceptable, flippant and offensive". Radius St Winifred's told HDC that all staff were questioned about this comment, and no one can recall making a statement to that effect.

72. The following day, 14 June 2012, a district nurse visited Mr A and recorded the following:

> "Today strikethrough +, toe has deteriorated +++ since I last viewed. Is black, pulpy around where toe nail was. Cellulitis coming up foot both top and bottom — marked with pen. Bottom of foot swollen. Also small wounds on both 2nd and 3rd toes … Heel wound has also deteriorated, periwound macerated and ulcer is deeper, minimal slough."

73. Later that day (14 June), Mr A was admitted to a public hospital, presenting with gangrene of his right big toe.

74. On 13 July 2012, Mr A's right leg was amputated above the knee. Mrs A told HDC:

> "[Mr A's] right leg has been his lifeline as he had a partial amputation on his left leg some years ago. At that time he was told by numerous clinicians to carefully guard his remaining leg which is what we had done. [Mr A] used his right leg to weight bear for transfers and mobility. It has also meant he was able to remain living in the family home with myself and my son."

Meeting with Radius St Winifred's

75. Following Mr A's right leg amputation, Mrs A contacted the Nationwide Health & Disability Advocacy Service. Mrs A went with an advocate to meet with RN B and RN D. Mrs A felt that at that meeting RN B and RN D were defensive, and that the answers they gave were not adequate considering her husband's outcome. Mrs A told HDC that RN B and RN D said that they were sorry for what happened to her husband but that they did not have any concerns about the care that was provided to him. Mrs A felt that the apology given by them was insincere.

76. RN B told HDC that the answers they gave Mrs A were factual, and they were very sad about Mr A's outcome. RN B said further: "We are very sorry if [Mrs A] feels that it was insincere, as that was not how I, the clinical manager, or the staff felt at St Winifred's. I spoke to [Mrs A] after the meeting and she seemed reasonably happy with the outcome or so I thought."

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Action taken since complaint

Changes implemented

77. RN B informed HDC: "On reflection after [Mrs A's] visit we investigated where we could have offered a higher standard of care."

78. The changes implemented by Radius St Winifred's include:

- The introduction of a wound care nurse who sights and assesses every wound, and draws up the Wound Care Plan. Radius St Winifred's advised that it recognised that there were too many occasions where the nurse attending to Mr A's wounds had never seen them before.
- Radius St Winifred's now uses respite patients' own dressings and not ward stock.
- Each wound, pressure sore, or skin tear has a separate wound care plan and well documented dressing changes.

79. RN D told HDC:

> "In my analysis, there were some gaps for us to work on, with our documentations which includes our wound management charts and short term care plans. The wound dressings were done by the registered staff but the documentation was very difficult to follow. We have identified this and we are now using a separate wound assessment and care plan for every pressure area. We have now good links with [the district nursing service] and the Diabetes Centre.
>
> Delay in communication and follow up was identified, this has been addressed and evidenced in continuous education sessions, meetings and forums.
>
> We have identified a problem of getting hold of GPs for our respite patients, we want them to be reassessed on time for any concerns, but this sometimes proves difficult."

Wound care audit

80. Radius St Winifred's provided HDC with two wound care audits from June 2013. Both audits show improvement with wound care documentation and interventions.

Responses to provisional opinion

81. Responses to the provisional opinion were received from Mrs A, Dr C and Radius St Winifred's, and have been incorporated into the "information gathered" section where relevant.

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Standards

Health and Disability Sector Standards NZS 8134.1.2: 2008

Service Management

Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

…

Family/whānau participation

Standard 2.6 Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

…

Consumer information management systems

Standard 2.9 Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Opinion: Radius Residential Care Limited (operating as Radius St Winifred's Hospital)

82. The New Zealand Health and Disability Sector Standards (NZHDSS) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.[33] Radius Residential Care Limited, as the operator of Radius St Winifred's, had the ultimate responsibility to ensure that Mr A received care that was of an appropriate standard and that complied with the NZHDSS and the Code.

83. Mr A was admitted to Radius St Winifred's for respite care between 24 May 2012 and 12 June 2012, a period of 18 days. There were several areas in which Mr A's care was suboptimal, in particular Radius St Winifred's care planning, management of Mr A's wounds, documentation, and communication.

84. I have carefully considered the extent to which the deficiencies in Mr A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational issues. The problems that arose with Mr A's care were not the result of isolated incidents involving one or two staff members. Six registered nurses, four enrolled nurses, and a number of healthcare assistants provided care to Mr A during

[33] NZS 8134.1:2008, Standard 2.2

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his 18-day admission. I am concerned that many of the shortcomings were common to a number of staff, indicating systemic problems.

Care and treatment — Breach

Assessment on admission and care planning

85. A resident's care plan is an essential tool for ensuring that the resident's care requirements are communicated to all staff involved in that resident's care. The admission assessment is the foundation on which to build a good care plan. It is the proper documentation of this process that ensures continuity of care.

86. In accordance with Radius's Clinical Manual, a Care Plan was completed on admission by RN E. RN E recorded that Mr A was diabetic and cognitively impaired, and that he required assistance with toileting, personal cleansing and dressing, controlling his body temperature, skin/pressure area care, and safety/mobility. In relation to mobility, she noted that Mr A used a manual wheelchair, but she did not record that his left leg had been amputated below the knee. There were no special care requirements listed for his dependent tasks.

87. There is no record of Mr A's baseline observations (temperature, blood pressure, pulse, respiration rate) having been taken at the time of his admission. Baseline observations are important for comparison in the event of a change in health status. I am critical that Mr A's baseline observations were not taken on admission.

88. There is no record of whether skin or pressure risk assessments were conducted. Radius's Skin Care Policy requires the initial Care Plan to identify any immediate risk a client may have for the breakdown of pressures areas. My expert nursing advisor, Ms Evans, noted:

> "[Mr A] was at a high risk of pressure areas especially with his heel, toe and stump due to his diabetes and poor blood circulation. There is no evidence of pressure area cares: the use of a pressure care mattress, sheepskin under heel or evidence of leg being elevated to reduce fluid and reduce pressure to heel."

89. There was no care plan developed for Mr A on how to avoid pressure area risks and maintain skin integrity. Ms Evans states that "the failure to complete a skin integrity and management risk assessment and a pressure risk assessment is a moderate departure from [the] expected standard of care". I consider that both pressure area care and maintenance of skin integrity are critical components in the appropriate provision of respite care, especially for patients such as Mr A, whose chronic wounds were at increased risk of poor or delayed healing owing to his diabetes.

90. At the time of admission, Mr A had four wounds. Radius's Wound Care Policy required that on admission all wounds be assessed by a registered nurse. RN E specifically noted in the special care requirements section of Mr A's Care Plan that he had a skin tear on his right leg, and the plan of care was to "check dressing daily, change when strike through". RN E stated that she did not have time to conduct a visual check of Mr A's other wounds, but handed over to the staff on the afternoon shift to complete the assessment. EN J completed a Wound Care Plan for Mr A's skin

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tear. There is no evidence that any of Mr A's other wounds were assessed by a registered nurse on admission. Mr A's wound assessment was incomplete, as no Wound Care Plans were completed for his right toe, right heel, or left stump as part of his admission assessment.

91. Radius's Clinical Manual required family/whānau to be consulted and included in care planning for clients at all times. Contrary to Radius's Clinical Manual, there was no consultation with Mr A's family as to the suitability of his Care Plan. In my view, family involvement in care planning is essential. Previously Mr A had been cared for at home by his wife, and was to be at Radius St Winifred's for only 18 days of respite care. Valuable information could have been obtained from Mrs A prior to admission, or from Mr A's family during his admission, which may have assisted staff in ensuring that Mr A received appropriate care.

92. I consider that there were a number of deficiencies in Mr A's admission assessment and his Care Plan. Ms Evans advised: "The Assessments and Care Plan completed by nursing staff do not appear to adequately identify the client's needs in order for safe care to be delivered." I agree that Mr A's admission assessment and Care Plan were not completed adequately, particularly in relation to the assessment and management of his wounds, skin integrity and pressure area risk. I consider that these deficiencies affected the ability of Radius St Winifred's staff to provide appropriate care.

Wound management

93. Mr A's wound care was inconsistent. As noted above, on admission a Wound Care Plan was completed by EN J. However, this form recorded only Mr A's right leg skin tear, and did not mention his right toe and heel wounds or his left stump. This is contrary to Radius's Wound Care policy, which requires all wounds to be thoroughly assessed and a care plan formulated with interventions appropriate for the specific wound and requirements of the client, including documentation of ongoing evaluation and dressing changes.

94. The Wound Care Plan 1 was subsequently amended on 28 May 2012 by RN G to include Mr A's heel wound. I am critical that not only was a separate Wound Care Plan not completed for each of Mr A's wounds at the time of admission, but that when the heel wound was subsequently identified, a separate Wound Care Plan form was not completed for it. This wound was present at the time of Mr A's admission and was detailed in the information provided to Radius St Winifred's by Mrs A.

95. A further Wound Care Plan was completed by RN F on 6 June 2012 for Mr A's toe wound. I find it unacceptable that this wound was first formally recorded 13 days after Mr A was admitted. This wound was also present at the time of Mr A's admission, and was also detailed in the information provided to Radius St Winifred's by Mrs A.

96. The Wound Care Plans required dressing changes to be performed every two days; however, dressing changes were documented only every three to five days. Ms Evans stated that there should have been a "minimum of two day dressing changes if not daily depending on wound status. The wound status is not observable unless the dressing is changed."

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97. I am concerned that Mr A's wounds were not identified and assessed in a timely manner. Once identified, the wounds were not reviewed regularly. Mr A's wounds were not managed in accordance with his Wound Care Plans.

98. It is also apparent that none of the staff properly evaluated Mr A's wounds or sought assistance from a doctor when his wounds began to deteriorate. It is difficult to tell when the deterioration began, as no baseline wound assessment was carried out on admission. However, on 6 June 2012 RN F recorded that the toe wound was black and necrotic. I am critical that Dr C was not called to review Mr A's toe wound at that time. Ms Evans advised me:

> "In my opinion the GP should have been advised of the significant change in wound bed of the right big toe when assessed as black and necrotic. There appears to be no consistency in wound assessment evaluation to how the wounds were progressing."

99. On 9 June 2012, RN H recorded on Wound Review Plan 1 that the wound margins were inflamed. There is no evidence of a wound swab being taken, and Dr C was not informed.

100. On 11 June 2012, EN K sighted Mr A's wounds for the first time. She recorded on Wound Review Plan 2 that his toe wound was black and necrotic. On Wound Review Plan 1 she recorded that Mr A's wound margins were inflamed. It is unclear whether she is referring to the skin tear, heel wound, or both. Again there is no evidence of a wound swab being taken, and Dr C was not informed.

101. Mr A's wounds had deteriorated significantly since his admission at Radius St Winifred's 17 days earlier. The day after Mr A was discharged from Radius St Winifred's, Mrs A "noticed [her husband's] sock covered in blood, the bandage had come off and his toe nail was literally floating on his toe". Mrs A took her husband to see Dr C and, the following day, Mr A was admitted to the public hospital with gangrene in his right big toe.

102. Mr A's wounds were not managed adequately by the nursing staff at Radius St Winifred's, and his wounds deteriorated. At no point was Dr C called to review Mr A's wounds. A significant failing was that there was no oversight of Mr A's wounds by one registered nurse. Almost every wound care review was performed by a different registered or enrolled nurse. I consider that this affected the ability of the nursing staff to identify changes to the wound status appropriately. As a result, there was no continuity with the dressing changes and the reviews undertaken by the registered and enrolled nurses. This had a significant impact on the wound care provided to Mr A. In my view, the wound care provided to Mr A was suboptimal.

Change in Mr A's health

103. On 26 May 2012, an enrolled nurse recorded that Mr A was talking in a confused manner. RN I recorded that a urine specimen was collected and a dipstick test performed. The dipstick test showed the presence of protein, glucose, and blood in the

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urine. RN I noted that the specimen was to be sent to the laboratory and the GP informed of the dipstick result.

104. Radius St Winifred's stated: "There is no evidence that the specimen taken on 26 May [2012] was sent to the laboratory and there is no result for that specimen." There is also no evidence to suggest that Dr C was informed about the dipstick result. Accordingly, I conclude that the urine specimen was never sent to the laboratory and that Dr C was not informed of the dipstick result.

105. From 27 May 2012 to 29 May 2012, no concerns were recorded in the progress notes. On 30 May 2012, RN E contacted Dr C, as a further dipstick test result showed "protein ++++ & urine had trace 10 of blood". On 31 May 2012, Dr C requested a urine specimen be sent for testing. The urine specimen results showed no signs of infection.

106. From 1 June to 6 June 2012 there are no concerns recorded in Mr A's progress notes. On the morning of 6 June 2012, Mr A was found to be dry retching, and he had a temperature of 38.3°C. RN E contacted Dr C by telephone, and he prescribed antibiotics and an anti-emetic. Dr C was not asked to review Mr A.

107. I consider the care provided to Mr A when his health status changed between 26 May 2012 and 6 June 2012 to have been poor. Dr C should have been asked to review Mr A when he was unwell on 6 June 2012. Ms Evans stated:

> "Considering [Mr A's] multiple co-morbidities, in my opinion the clinical manager or registered nurse on behalf of [Mr A] should have requested a review to be seen by the GP. In my opinion there has been a moderate to severe departure from expected standards of care, not following up on the change in general health for [Mr A]."

108. I agree with Ms Evans that the inaction by Radius St Winifred's staff meant that the care provided to Mr A fell below expected standards. In my view, Radius St Winifred's did not ensure that Mr A's change in health status was adequately assessed, documented, or managed.

Summary

109. Radius Residential Care Limited (operating as Radius St Winifred's Hospital) failed to provide services to Mr A with reasonable care and skill with regard to his admission assessment, care planning, wound care and assessment, and follow-up of his change in health status. In my view, Radius Residential Care Limited breached Right 4(1) of the Code.

Compliance with standards — Breach

Documentation

110. The NZHDSS require that consumer information is "uniquely identifiable, accurately recorded, current, confidential, and accessible when required".[34] This includes

[34] NZS 8134.1:2008, Standard 2.9.

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ensuring that good clinical records are kept and documentation remains up to date. This is essential to providing good care of an appropriate standard.

111. The importance of good documentation cannot be overstated. As noted in an earlier HDC opinion relating to the provision of residential care:[35]

> "The clear and accurate documentation of a resident's condition and the care provided is not optional. It is a means by which relevant information is shared between those providing care and treatment, and is a key component of effective teamwork."

112. Radius's record-keeping policy requires records to provide "an accurate account of care delivered and permit communication among health professionals". With six registered nurses, four enrolled nurses, and a number of healthcare assistants attending to Mr A, it was of critical importance that progress notes were clear, to enable those on the next shift to provide appropriate care.

113. Although progress notes were recorded daily for Mr A, important details about the care provided are missing. On 26 May 2012, RN I recorded in the progress notes that a urine specimen was to be sent to the laboratory, and that Dr C should be informed of the dipstick test result. There is no record in the documentation that the specimen was sent to the laboratory, or that Dr C was informed of the dipstick result.

114. Similarly, on 30 May 2012, Dr C requested that a urine specimen be tested. Despite test results being available, the progress notes do not record that the specimen was taken, that it was sent to the laboratory, what the results were, or whether or not the results were communicated to Dr C. Ms Evans advised: "Daily notes of general condition and care of wounds appear insufficient and difficult to follow continuity of treatment." I agree that the care provided to Mr A is hard to piece together from the documentation.

115. In relation to the wound care documentation, some of the dressing changes were recorded in the Wound Care Plans, while others were recorded in the progress notes. It also appears that there may have been dressing changes that were not documented. On 4 June 2012, a note in the margin of the progress notes states, "undocumented dressing change". RN D acknowledged that the wound care documentation was difficult to follow.

116. In Mr A's "Discharge Plan" there is no mention of the change in Mr A's health status or the worsening of Mr A's wounds, particularly to his right toe, or that he was prescribed antibiotics during his stay. I consider that it would have been appropriate for this information to be included in the discharge plan.

Communication with family

117. The NZHDSS require families to be "involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals".[36]

[35] See Opinion 08HDC17309, available at www.hdc.org.nz/publications.
[36] NZS 8134.1:2008, Standard 2.6.

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118. As already noted, I consider that valuable information could have been obtained from Mrs A prior to admission, or from Mr A's family during his admission. I also consider that Mr A's family should have been kept better informed about changes to his health status during his stay at Radius St Winifred's. On 6 June 2012, RN E recorded in the progress notes that Mr A's son rang and was notified that Mr A was unwell. This is the only recorded instance of Radius St Winifred's staff communicating with Mr A's family. Ms Evans advised that the "communication with family appears poor regarding the changing condition of [Mr A's] wounds especially at discharge".

Summary

119. Radius Residential Care Limited's documentation and communication with Mr A's family did not meet the NZHDSS. Mr A had a right to have services provided to him that complied with relevant standards. Accordingly, I consider that Radius Residential Care Limited breached Right 4(2) of the Code.

Communication — Breach

120. There were lapses in communication between Radius St Winifred's staff and Dr C. On 26 May 2012, Radius St Winifred's staff did not follow up on Mr A's urine specimen results from the laboratory, and did not inform Dr C about Mr A's dipstick test result.

121. There is also no evidence that Dr C was contacted about the deterioration of Mr A's wounds. Except for a fax sent on 31 May 2012, there is no record of the information Radius St Winifred's provided to Dr C when he was contacted about Mr A.

122. In my view, Radius Residential Care Limited's staff failed to communicate effectively with one another and with Dr C to ensure that Mr A received quality and continuity of services. Accordingly, I find that Radius Residential Care Limited (operating as Radius St Winifred's Hospital) breached Right 4(5) of the Code.

Wound care products — Adverse comment

123. Mrs A provided Radius St Winifred's with Omnifix and crêpe bandages for Mr A's wound dressings. Mrs A also provided Radius St Winifred's with copies of case notes from both Mr A's podiatrist and the district nursing service.

124. The dressings provided by Mrs A were not used. Ms Evans advised:

> "The dressing products used by Radius St Winifred's on [Mr A], ie Hydrofilm, Tegaderm and PolyMem, are waterproof dressings and are designed to allow up to seven days between changes depending on absorbency and wound status. In my opinion these dressings may not have been appropriate for [Mr A's] wounds, as his wounds required more regular dressing to monitor the fragile wound status."

125. Radius St Winifred's told HDC that its staff did not see the dressings provided by Mrs A as they were placed in the cupboard. It also told HDC that it did not use the dressings in order to save them for Mrs A. Mrs A cannot recall whether she spoke to a nurse about the bandages on admission. I am unable to make a finding as to whether the nursing staff were aware that Mrs A supplied dressings. However, in my view, it

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would have been prudent for Radius St Winifred's to have thoroughly reviewed the case notes provided by Mrs A, as they contained details of the dressings previously used by Mr A's podiatrist and the district nurses. This would have helped to ensure continuity of the healing process. Radius has subsequently advised that it now uses respite patients' own dressing stock where that is provided.

Other comment

126. Mrs A told HDC that when discussing Mr A's adverse outcome with a nurse at Radius St Winifred's, the nurse said, "[T]hat's what happens to diabetics' toes." Mrs A found the remark to be unacceptable, flippant and offensive. Radius St Winifred's questioned its staff members about this statement, and no one could recall making it. I am unable to make a finding as to whether or not the remark was made. However, I remind Radius St Winifred's that it must take care in its communication with families, and ensure that appropriate explanations are given.

Dr C — Adverse comment

127. On 6 June 2012, RN E telephoned Dr C regarding Mr A. Radius St Winifred's progress notes record that Dr C charted antibiotics over the telephone. I am critical that Dr C's notes do not contain a record of his communication with Radius St Winifred's, a record of the antibiotics that he charted, and the reasons for charting those antibiotics.

Recommendations

128. I recommend that Radius Residential Care Limited (operating as Radius St Winifred's Hospital):

- Provide a written apology to Mr A. The apology is to be sent to HDC within **two weeks** of the date of this report, for forwarding to Mr A.
- Conduct an audit of its wound care documentation and report the results of the audit to HDC within **three months** of the date of this report.
- Conduct a review of the effectiveness of the introduction of its wound care nurse and report back to this Office within **one month** of the date of this report.
- Confirm its plans to ensure timely contact and follow-up with general practitioners, conduct a review of the effectiveness of this, and report back to this Office within **one month** of the date of this report.
- Provide to HDC, within **one month** of the date of this report, a list of in-service training courses offered by Radius Residential Care Limited for registered and enrolled nurses for the next calendar year. Courses offered should include such topics as documentation, wound care, care planning, admission assessments, and communication.

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- Use this report as a basis for staff training at Radius Residential Care Limited, focusing particularly on the breaches of the Code identified, and provide evidence of that training to HDC within **three months** of the date of this report.
- Conduct an audit of patient records to assess compliance with documentation policies and professional standards, and report the results of this audit to HDC within **three months** of the date of this report.

Follow-up actions

129.
- Radius Residential Care Limited will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Radius Residential Care Limited (operating as Radius St Winifred's Hospital), will be sent to the District Health Board and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

130. The Director of Proceedings filed a claim at the Human Rights Review Tribunal which proceeded by agreement. The Human Rights Review Tribunal made a declaration that the providers had breached Right 4(1) of the Code.

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Appendix A — Independent nursing advice to the Commissioner

Preliminary advice was obtained from Ms Carolyn Evans, a registered nurse with expertise in aged care. Ms Evans reviewed her advice following the commencement of the investigation, once further documents had been obtained. Her amended report is as follows:

"**Reference: C12HDC01229**

My full name is Carolyn Heather Evans and I have been asked to provide my opinion to the Commissioner on case number C12HDC01229, I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Registered Nurse and completed my Bachelor of Nursing Degree 2003 at Waikato Institute of Technology. I spent time working at Waikato Hospital in the Oncology Department and Operating Theatre. I commenced as Nurse Manager of Windermere Resthome in Cambridge (2005). Responsibilities include: managing the care of 21 Residents; recruitment, training and supervision of all nursing and allied staff: liaising with families and health professionals: developing quality management systems, including auditing and assessments.

The purpose of this report and advice is to enable the Commissioner to determine whether, from the information available, there are concerns about the nursing care provided by Radius St Winifred's Hospital (RSW) which may require further action. The focus of my advice relates to:

1. Whether the nursing care provided by RSW was appropriate. Detailing any departures from expected standards of care and advising if departures from expected standards are mild, moderate or severe.

2. Whether the wound care provided to [Mr A] by RSW was consistent with expected standards of care and advising if departures from expected standards are mild, moderate or severe.

Information Reviewed:

- Mrs A's complaint and supporting documents
- [Mr A's] clinical notes from [the] District Health Board
- Response from RSW dated 19 November 2012
- [Mr A's] clinical notes from RSW

Subsequent documents reviewed 25 June 2013

- **HDC Notification letter dated 17 May 2013**
- **Dr C's response dated 16 May 2013 and his GP notes.**
- **Radius residential Care (Radius St Winifred's Hospital) response to notification dated 5 June 2013 and enclosures**
- **Emails to/from RN B dated June 2013.**

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Summary of Complaint

[Mr A] was placed in respite care at RSW for 17 days while his wife [went overseas]. [Mr A's] left leg was partially amputated a number of years ago, and he had a wound on his right toe that had been managed since 2008 using latex-free Omnifix. On admission to RSW, [Mrs A] provided the hospital with crepe bandages and latex-free Omnifix to use for dressing her husband's wound. These dressings were not used during the course of [Mr A's] time at RSW.

The day after [Mr A] left RSW, [Mrs A] noticed his wound was bleeding, so she took him to the GP. The next day, [Mr A] was admitted to [a] Public Hospital and it was found his wound had deteriorated to such an extent his right leg had to be amputated.

Advice

[Mr A] was admitted to RSW for Respite Care on the 25/5/12 and discharged home on the 12/6/12.

[Mr A's] past medical history includes multiple co-morbidities; Delirium with chest infections, Chronic Renal Impairment, Pulmonary Vascular Disease, CVA, Diabetes Type 2, Diabetic Retinopathy, Hypertension, Ischaemic Heart Disease, Below Knee Amputation L) leg, Dyslipidaemia (abnormal amount of lipids in blood).

[Mr A] had undergone a previous R) leg angioplasty for critical limb ischaemia. See letter from [Dr M] Vascular Surgeon (10/4/12). [Dr M] noted should [Mr A's] wounds deteriorate he was to be seen by himself as a matter of urgency as he suspected this would indicate his angioplasty had thrombosed.

15/6/12 CTA Lower Limbs Superficial femoral artery and popliteal artery occluded. (See [the] District Health board Clinical Notes)

20/6/12 [The] District Health Board Radiology Letter notes R) Lower limb angioplasty — occluded. Due to [Mr A's] multiple co-morbidities he was a high risk Respite Care resident, therefore a comprehensive Short Term Care Plan in my opinion would be necessary.

Assessment and Short Term Care Plan

Respite clients are entitled to a co-ordinated Short Term Care Plan and Discharge Planning. An admission assessment should be completed within 24 hours of admission by an RN identifying the resident's health and personal care needs in a care plan. Assessment should utilise information from resident, family and other health personnel care services. Information had been provided by [Mrs A] (see supporting document [Mr A] 24/5/12). There were notes from the Registered Nurse from [the district nursing service] who viewed [Mr A] on the 21/5/12 and the Podiatrist who viewed [Mr A] on the 24/5/12. A Short Term Care Plan should provide Baseline information, resident's health status, abilities, supports and needs. The Short Term Care Plan should assess the client's health and support

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needs to maintain level of functioning during respite care. Risk Screening Tools to assist with assessment for Respite Care Resident include:

Skin Integrity and Management Risk Assessment

Pressure Risk Assessment and Pressure Ulcer Staging

Nutrition and Diet Assessment

Wound Care Assessment

Pain Assessment

Falls Risk Assessment

Continence Assessment

The Short Term Care Plan should be updated based on regular evaluation. The care plan is evaluated and reviewed and amended when clinical condition changes. Careplans are available to all staff to guide delivery of care and ensure continuity of support and treatment. Residents' family should be involved in discharge process.

There does not appear to be any evidence of a Short Term Care Plan completed by the Registered Nurse for [Mr A] on or shortly after admission to RSW 25/5/12. In my opinion failure to complete a Short Term Care Plan is a moderate to severe departure from expected standards of care.

25/6/13 Subsequent Information

Radius Care has an Assessment, Care Planning & Review Clinical manual — Policy & Procedure. There is evidence of a Respite/Short Term Assessment Care and Discharge Plan signed on the 25/5/12 by the RN. However there is no evidence of initial observations of Temperature, BP, Pulse, Resps or Allergies documented. There is no documentation in the special comments or special care requirements on skin/pressure area assessment. The Care Plan only documents the problem of the skin tear on R) leg. There is no evidence of documentation regarding the compromised R) toe or R) heel. The Care Plan Summary was signed 29/5/12 by the EN. There is no documentation regarding the R) toe or R) heel or of [Mr A's] Below Knee Amputation (BKA) of the L) leg. The Radius Care Policy and Procedures appear to be appropriate. However, the Assessments and Care Plan completed by nursing staff does not appear to adequately identify the client's needs in order for safe care to be delivered.

In my opinion failure to complete a Short Term Care Plan is a moderate to severe departure from expected standards of care.

Pressure Risk Assessment

[Mr A] was at high risk of pressure areas especially with his heel, toe and stump due to his Diabetes and poor blood circulation. There is no evidence of pressure area cares: the use of a pressure care mattress, sheepskin under heel or evidence of

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leg being elevated to reduce fluid and reduce pressure to heel. There is no evidence of use of a protective cradle for over the foot preventing the weight of blankets on [Mr A's] bed causing pressure on his toe. There is no documented evidence of maintaining skin integrity by moisturising the skin on his R) leg.

25/6/12 Subsequent Information

There is evidence in the Care Plan Summary of maintaining skin integrity by moisturising the skin. However as I have stated above there is no evidence of documentation of [Mr A's] R) big toe or R) heel, or BKA of the L) leg and the appropriate interventions to meet [Mr A's] needs.

In my opinion failure to complete a Skin Integrity and Management Risk Assessment, and Pressure Risk Assessment is a moderate departure from expected standard of care.

Changes in [Mr A's] Medical Status

25/5/12 'Dr faxed regarding medication chart. Faxed Dr to change the dose of insulin.'

26/5/12 [Mr A] appeared confused. Urine sample was dipsticked, urine sample collected and documented to be sent to laboratory.

30/5/12 Follow-up phone call to GP re: urine specimen, Second urine specimen requested, collected and sent to Laboratory.

6/6/12 [Mr A] febrile and nauseous, 'dry retching and temperature 38.3'. GP faxed and advised. GP faxed back order for antibiotics to commence for chest infection.

6/6/12 [Mr A] complaining of pain on Right toe. Documentation states 'wound bed black and necrotic'.

9/6/12 Documentation indicates wound margins appeared inflamed.

[Mr A's] general health status had changed. However, there appears to be no evidence of the urine specimen results from the laboratory and the follow-up treatment if required (see 26/5/12, 30/5/12). There is no evidence of a wound swab being taken and sent to laboratory querying an infected wound (see 9/6/12). There is no documented evidence advising the GP of the change in wound status. There does not appear to be any further evaluation, follow-up documentation of this change with the R) big toe. (see 6/6/12). The 6/6/12 was a Wednesday and not a Friday as stated by the Facility Manager (see letter 19/11/12). Considering [Mr A's] multiple co-morbidities, in my opinion the Clinical Manager or Registered Nurse on behalf of [Mr A] should have requested a review to be seen by the GP.

In my opinion there has been moderate to severe departures from expected standards of care, not following up on the change in general health for [Mr A].

25/6/12 Subsequent Information

There is evidence a fax was sent to the GP on the 31/5/12 advising him of a query for a urine infection and a urine specimen to be sent to the lab. The lab

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results were received 5/6/12 and the GP phone faxed an order for Antibiotics on the 6/6/12.

In my opinion there has been a moderate departure from expected standards of care, not following up on the change in general health and wounds for [Mr A].

Communication

Communication with family appears poor regarding the changing condition of [Mr A's] wounds especially at discharge. The appropriate information regarding the deteriorating or change in wound status of [Mr A's] wounds on his toe and heel does not appear to have been communicated to [Mr A's] family or GP. The family raised concerns when visiting [Mr A] regarding his 'wound having no dressing on it and he was observed barefoot with a sandal on'. Another family visit they requested the 'wounds be redressed as they were leaking fluid from the dressings'. There is no documented communication or action documented on these concerns by RSW.

In my opinion there has been a moderate to severe departure from expected standard of care.

26/6/13 Subsequent Information

In my opinion there has been a moderate departure from expected standard of care.

Wound Care Assessment

On admission the Registered Nurse should inspect and assess the wounds. Complete the wound assessment form. Take a swab of the wound if it appears infected and send to laboratory to determine type of infection. The RN would plan for which type of dressing was required, depending on wound status. Assess pain relief if required. Assess nutrition and diet requirements. Elevate the affected leg to reduce swelling and provide comfort. Write in daily progress notes about resident's general condition and care of wound. Document wound care plan. Review and evaluate as necessary. Involve the resident/family with planning and intervention. Advise GP of any changes in health status or support needs and request review.

Wound Assessment and Care Plan (Skin Tear) dated 24/5/12

Wound Type: Skin Tear grade 2

Size: 4cm skin tear.

Risk factors for healing: diabetic.

Slight pain present.

Primary dressing: PolyMem

Secondary dressing: Omnifix.

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Frequency of dressing change every 2nd day, with next change due 26/5/12.

The Wound Review Plan indicates an assessment of the Right heel and Right lower leg, dated **28/5/12, 2/6/12, 9/6/12, 11/6/12.**

Wound Assessment and Care Plan (Toe on Right Foot) dated 6/6/12

Wound Type: Pressure sore grade 3.

Size: 1.5cm long by 1cm wide and approx. 2mm deep.

Risk factors for healing: Diabetic. No pain present.

Primary Dressing: PolyMem.

Secondary dressing: gauze.

Frequency of dressing change: every 2 days with next dressing change due 8/6/12. The Wound Review Plan has only one assessment date **11/6/12**.

Nursing Progress Notes

25/5/12 'Redressed skin tear on R upper leg as per care plan'

28/5/12 'Right upper leg dressing changed as per wound care plan'

28/5/12 'Noticed pressure sore R heel — cleaned with betadine and covered with gauze and tegaderm to secure (please refer wound chart)'.

2/6/12 'wounds redressed as per wound care management plan'.

4/6/12 I am unsure if dressings changed as not clearly documented in progress notes.

6/6/12 'Wound bed is black and necrotic wound dressed … wound chart written'.

11/6/12 'found the dressing came off, informed RN'

11/6/12 'Dressing done today'

There is no evidence of a visual wound assessment by the Registered Nurse on the day of [Mr A's] admission to RSW (25/6/12). The Pressure ulcer on R) heel was noted as first observed on the 28/5/12. The Wound Review Plan is incomplete for documenting changes in wound bed and wound margins. The Wound Assessment documents the frequency of dressing changes to be every 2 days, however actual dressing changes were documented between 3–5 days between dressings. Daily notes of general condition and care of wounds appear insufficient and difficult to follow continuity of treatment. The evaluation overview for the wound dressings indicated wound status remained unchanged or as the first time being seen by the staff member changing the dressing. When the R) toe wound bed was documented as being black and necrotic in the progress notes 6/6/12, there is no evidence of corresponding wound review plan being evaluated at this time. There appears to be inconsistency with progress notes documenting when dressings were changed and when the Wound Review Plan was completed. The Wound Review Plan for the location of each wound is misleading. There is no evidence of the secondary

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dressings providing protection for the toe and heel with using softban, gamgee or crepe bandage to protect the foot from knocks and for comfort.

Please refer to: Investigation: [Mr A] (Information reviewed not dated and no signature as to who wrote this report). Have noted the Heel and Toe dressings were redressed at least 5 times each (4 documented and one undocumented). If dressing changes were not documented in the Nursing Progress Notes or in the Wound Review Plan then they are deemed not to have happened.

In my opinion the wounds should have all been visually assessed by the RN on admission then minimum of two day dressing changes if not daily depending on wound status. The wound status is not observable unless the dressing is changed. In my opinion the GP should have been advised of the significant change in wound bed of the R) Big toe when assessed as black and necrotic. There appears to be no consistency in wound assessment evaluation to how the wounds were progressing.

Wound Care Products

Secondary dressings used by the Podiatrist and [district nurses] were latex-free omnifix and crepe bandages. [Mrs A] wrote they had trialled plastic bandages and had found them not suitable for [Mr A]. The dressing products used by RSW on [Mr A] ie. Hydrofilm, Tegaderm and PolyMem are waterproof dressings and are designed to allow up to 7 days between changes depending on absorbency and wound status. In my opinion these dressings may not have been appropriate for [Mr A's] wounds, as his wounds required more regular dressing to monitor the fragile wound status.

25/6/2013 Subsequent Information

The Facility Manager states 'they have a wound care nurse who sites every wound, assesses and draws up the wound care plan. Wound care audits are to be completed six monthly and are now added to the Radius Quality Programme'. The Clinical Manager also states 'they are using separate wound assessment and care plan for every pressure area'. In my opinion these changes are highly recommended.

There is evidence of education records provided for the following training:

- **Care plans 1/12/11**
- **Dressings 26/3/12**
- **Communication 2/5/12**

Regarding the systems/arrangements in place at RSW's for staff to communicate residents' care needs and changes. The Clinical Managers report (p509) has identified the delay in communication and follow-up. And state 'this has been addressed and evidenced in continuous education session, meetings and forums'. The Clinical Manager has also identified there is a

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problem accessing the GP for their Respite patients but I am unsure how this is being remedied.

In my opinion it is difficult to identify individual members of staff causing the breakdown in care for [Mr A] as there were a number of RNs and ENs nursing [Mr A] while he was at RSW's.

In my opinion there may have been systemic factors of communication impacting on the ability of nursing and care staff to provide adequate care. It appears the Clinical Nurse Manager was only appointed to her role 9 days prior to [Mr A's] admission. It is also difficult to ascertain what the work load for staff was at the time of [Mr A's] admission.

Summary

In my opinion there was a moderate to severe departure from expected standards of care for [Mr A]. In my opinion RSW failed to use appropriate care and skill when assessing, planning, implementing and evaluating the Wound Care Assessment and Short Term Care Plan for [Mr A]. In my opinion RSW also failed to action and follow-up changes in [Mr A's] condition regarding wound status, urine specimen and pressure area care.

Recommendations

In my opinion it would be in the best interest of the Resident and RSW to have a GP review Respite residents at time of admission.

For RSW to review Policy and Procedures for Admission and Assessment of Respite Residents.

To provide Pressure Area Risk and Pressure Area Cares education to nursing staff at RSW.

To ensure Policy and Procedures on pressure air mattresses are available and the process on how to order, install and when to remove are in place at RSW.

To provide Wound Assessment and Wound treatment, evaluation and documentation education to nursing staff at RSW.

To include Communication Strategies in RSW staff educational calendar.

To develop a Policy and Procedure enabling nursing staff to access advice from specialist services within the Community. For example: DHB wound care specialists; Community Diabetic Team; [district nurses], which has a wound management service that provides consultation and advice on wound management to GP's, Community and Practice Nurses, Resthomes and Private Hospitals.

Carolyn Evans, Registered Nurse"

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