The Ultimate Care Group Limited
(trading as Ultimate Care Karadean Court)
Clinical Services Manager, RN D
Clinical Services Manager, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00352)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation....3
Relevant standards....26
Opinion: The Ultimate Care Group Limited — breach....27
Opinion: RN D — adverse comment 38
Opinion: RN C — adverse comment....41
Recommendations....44
Follow-up actions 46
Addendum....46
Appendix A: Independent advice to the Commissioner 47

Executive summary

1. This report concerns the care provided to a man by Ultimate Care Group Limited (Ultimate Care Group) during his admission for hospital-level care. During his residency, his health deteriorated and he required interventions to manage his continence, hydration, medication, diabetes, podiatry, pressure areas, and pain. Overall, there was a lack of attention and responsiveness to his condition by multiple staff, and a lack of oversight by the clinical managers.

2. The report highlights the importance of providers ensuring that clinical assessments and care plans are accurate, comprehensive, and actioned, and that documentation is completed to a good standard to support care and decision-making, and to alert providers to changes in a resident's condition. It also highlights the importance of providers seeking specialist advice in a timely manner and communicating effectively with one another, and reinforces the importance of aged-care residential facilities ensuring that staffing levels and skills are adequate to deliver an appropriate standard of care to residents.

Findings

3. The Deputy Commissioner was critical that Ultimate Care Group did not review the man's continence care accurately; did not arrange podiatry reviews; did not monitor the man's diabetes adequately; did not manage the man's pain relief adequately; did not obtain an air-relieving mattress; did not record the man's wound care documentation accurately; did not monitor the man's pressure wounds adequately or seek specialist advice in a timely manner; did not reflect the man's health status accurately in documentation; did not manage his faecal incontinence, ankle and sacral pressure areas, and pain and redness of his scrotal area adequately; did not have sufficient registered nurses available to provide oversight to junior staff; and did not ensure adequate leadership over staff. Accordingly, the Deputy Commissioner found Ultimate Care Group in breach of Right 4(1) of the Code.

4. The Deputy Commissioner was critical that RN D, as the Clinical Services Manager, did not provide sufficient monitoring and oversight of the documentation, and did not provide effective nursing care in relation to pressure areas, pain management, continence care, and podiatry care.

5. The Deputy Commissioner was critical that RN C, as the Clinical Services Manager, did not provide adequate oversight of the continence care, wound care, and documentation, and did not adhere to the incident reporting policy.

6. The Deputy Commissioner referred Ultimate Care Group to the Director of Proceedings.

Recommendations

7. The Deputy Commissioner recommended that Ultimate Care Group provide training to its staff on pressure area prevention, pain management, and oversight by the Clinical Services Manager; audit compliance with policies developed in response to this complaint; review its

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

staffing levels, induction and training programme, and equipment and supplies; and provide a formal written apology to the man's family.

8. In accordance with a recommendation in the provisional opinion, RN D completed training in clinical documentation. The Deputy Commissioner recommended that RN D also undertake training on care planning and assessment, and provide a formal written apology to the man's family.

9. In accordance with a recommendation in the provisional opinion, RN C completed training in clinical documentation and wound care management. The Deputy Commissioner recommended that RN C also undertake training on assessment, communication, and clinical leadership, and provide a formal written apology to the man's family.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from the family of the late Mr A concerning the care he received at Ultimate Care Karadean Court (The Ultimate Care Group Limited). The following issues were identified for investigation:

- *Whether The Ultimate Care Group Limited provided Mr A with an appropriate standard of care between Month2[1] and Month14.*
- *Whether RN C provided Mr A with an appropriate standard of care between Month2 and Month14.*
- *Whether RN D provided Mr A with an appropriate standard of care between Month2 and Month14.*

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

12. The parties directly involved in the investigation were:

Mrs B	Consumer's daughter/complainant
RN C	Provider
RN D	Provider
The Ultimate Care Group Limited	Provider

[1] Relevant dates are referred to as Months 1–14 to protect privacy.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

13. Further information was received from:

District health board (DHB)	
Dr E	General practitioner (GP)
Dr F	GP

14. Also mentioned in this report:

RN G	Registered nurse
Medical centre	
RN H	Nurse specialist
RN I	Registered nurse
RN J	Registered nurse
RN K	Registered nurse

15. Independent expert advice was obtained from RN Rachel Parmee (Appendix A).

Information gathered during investigation

Introduction

Mr A

16. Mr A, aged in his eighties at the time of these events, was a resident at Ultimate Care Karadean Court (Karadean). Mr A was admitted to hospital-level care at Karadean owing to his increasing care needs approximately six years prior to events. Mr A had a history of a heart attack (NSTEMI),[2] and a number of health conditions including atrial fibrillation,[3] Type 2 diabetes,[4] hypertension,[5] stroke, hypothyroidism,[6] ischaemic heart disease,[7] and vascular dementia.[8] Mr A required a walking frame for mobilising short distances, and one-person assistance for showering, dressing, and toileting. Mr A had a Do Not Resuscitate order in place signed by Mr A and his GP the year prior to events.

17. On 21 Month14, Mr A had a suspected parotid gland obstruction and was prescribed a course of antibiotics. He was tired and responding only to sounds. After two unsuccessful

[2] Non ST-Elevation Myocardial Infarction (a heart attack).
[3] An irregular, rapid heartbeat.
[4] A chronic condition that affects the way the body metabolises sugar.
[5] Abnormally high blood pressure.
[6] An underactive thyroid gland.
[7] Heart disease characterised by reduced blood flow to the heart.
[8] A common type of dementia caused by reduced blood flow to the brain.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

attempts to administer antibiotics he was transferred to hospital, where he died on 24 Month14 as a result of septicaemia[9] and facial cellulitis.[10]

18. This report discusses the management of Mr A's continence and hydration, medication, diabetes, and podiatry, and his pressure areas and pain, between Month2 and Month14.

Ultimate Care Karadean Court

19. Karadean is owned and operated by The Ultimate Care Group Limited (UCG). Karadean is one of the care facilities contracted by the DHB to provide hospital-level and rest-home-level care to consumers in the region. Karadean received a three-year certification from the Ministry of Health in October 2014,[11] and a surveillance audit was undertaken by its designated auditing agency in 2016.

Clinical Services Manager

20. The position description for the Clinical Services Manager (CSM) role at Karadean states that the purpose of the role is to provide a high level of clinical leadership and support to clinical and care staff. It also states that the role entails monitoring the provision of care to residents, and providing oversight of all resident clinical records to ensure that they meet the organisation's requirements and legislative requirements.

Clinical Services Manager RN D — Month2 to Month10

21. At the time of these events, RN D was the Clinical Services Manager until her resignation in Month10, but she remained at Karadean in the role of a registered nurse.

Clinical Services Manager RN C — Month11 to several months after these events

22. RN C was the Clinical Services Manager at Karadean from Month11 until late 2016. This was RN C's first appointment as a Clinical Services Manager. In response to the provisional opinion, RN C told HDC that he resigned from his position as the Clinical Services Manager and then worked a further two months of his notice period.

Continence and hydration management

23. Between 22 Month2 and 10 Month14, the clinical notes by various staff members document 33 occasions on which Mr A was incontinent of urine and faeces.

24. Mr A's continence assessment was commenced on 17 Month1. It was recorded that he was incontinent of urine, but continent of faeces, and that he used continence products during the day and night. It was noted that Mr A required assistance from staff with his toileting regimen, which included before meals and during the night. Mr A's decrease in mobility and history of stroke were recorded as factors contributing to his incontinence.

[9] An infection of the blood.

[10] A bacterial infection of the skin and underlying tissues.

[11] The audit identified three areas as requiring improvement, relating to the integration of residents' notes, care plan interventions, and faxed medication records.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

25. On 26 Month7, a nurse assessed Mr A's continence and recorded that he was incontinent during the day and night, but the outcome of the review was unchanged from his previous assessment on 17 Month1.

26. RN D told HDC that the continence review on 26 Month7 was inaccurate, and should have recorded that Mr A's continence had "changed".

27. On 3 Month9, under the "Elimination bowels/bladder" section of the resident lifestyle plan[12] (RLP) it was recorded: "[Mr A] requires prompting to go toilet after breakfast to prevent having skin breakdown on groin due to being soaked in faecal matter."

28. On 28 Month10, a registered nurse commenced Mr A's new RLP. In the section "Elimination bowels/bladder", it was recorded that Mr A was incontinent of urine and faeces and required prompting when using the toilet. In the section "Intervention and care", it was recorded:

"• Ensure to assist [Mr A] when using the toilet.
- Monitor bowel motion and report appropriately.
- Ensure to use appropriate incontinence product and report if need to be reassessed.
- Promote proper/good hygiene by hand washing and proper cleaning of private areas.
- Administer laxatives or medication for loose bowel motions as per medication chart.
- Document and report any changes."

29. On 28 Month10, a nurse reviewed Mr A's continence assessment and recorded the outcome as a "change" in relation to his toileting regimen. It was recorded that staff would assist Mr A with toileting after breakfast, and continue to review him every two to three hours at night.

30. With regard to the continence assessment on 28 Month10, RN D told HDC that the changes made to Mr A's toileting regimen reduced the incidence of incontinence. She stated: "[O]n occasion [Mr A] would decline to be toileted and lacked insight around his continence related to [his short-term memory loss]."

31. RN D recalls that around then the caregivers failed to report to the registered nurses when Mr A was non-compliant around toileting. She said that education was provided to staff about the importance of reporting these incidents so that timely interventions could be made. RN D told HDC that loperamide[13] was charted as required, and she considers that this should have been used more effectively to manage Mr A's incontinence. RN D stated that

[12] An individual lifestyle care plan is completed within 21 days of admission to Karadean. The plan focuses on the resident's problems, and sets goals for addressing these or promoting health and any interventions required.

[13] On year prior to events, Mr A was charted loperamide 2mg every 8 hours or as required for diarrhoea.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

she did not have time to check on every nurse's assessment, and instead relied on the nurses to report on their assessments and care of their primary residents.

Month14

32. On 2 Month14, RN C reviewed Mr A's continence assessment and recorded that the outcome was unchanged. He noted that Mr A required assistance with toileting after breakfast, and checks every two to three hours at night, and that he continued to use continence products. The section "Remains Continent" is blank. On the same day, RN C updated the "Elimination bowels/bladder" section of the RLP and recorded: "[Mr A] continues to be toileted every 3–4 h[ours] + PRN.[14]"

33. At 4am on 12 Month14 it was documented that Mr A had vomited and had had an episode of diarrhoea. He was placed in isolation owing to an outbreak of norovirus,[15] and a Short Term Care Plan was commenced to prevent dehydration. The plan directed staff to monitor Mr A's input and output of fluids, and to encourage his fluid intake.

34. On 13 and 14 Month14 staff recorded that Mr A had had multiple incidences of loose bowel motions, and that he was not eating or drinking well.

35. On 14 Month14, it was recorded that RN G telephoned Mr A's wife and advised that he was not eating or drinking well. There is no documentation that any staff member notified Mr A's family that he was suffering from the symptoms of norovirus.

36. On 15 Month14, Dr E[16] attended Karadean for the usual rounds. Dr E was asked to review Mr A owing to concerns about his norovirus symptoms of vomiting and diarrhoea, and his decreased food and fluid intake. Dr E examined Mr A and recorded her impression of gastroenteritis[17] and dehydration. She also noted:

> "Inhibace Plus[18] stopped for now. Will consider resuming it in 3/7. Nursing strongly encouraged to push oral rehydration. If p[atient] doesn't consume 500ml PO fluid by 1.30pm today, plan is to administer 500ml S[ubcutaneous]. Nursing to notify provider if S[ubcutaneous] fluid administration is considered. P[atient] is for hospital transfer if acutely unwell."

37. At 3.30pm, RN D commenced a fluid balance chart[19] for Mr A, and recorded that staff were to encourage his fluid intake. She noted that since 11am Mr A had taken 1100mls, and that subcutaneous fluids were charted if required, but that he was tolerating fluids well. She recorded that the next GP review was to be on 18 Month14, or sooner if clinically indicated.

---

[14] As required.
[15] A contagious virus that causes vomiting and diarrhoea.
[16] A GP from the medical centre.
[17] Inflammation of the gastrointestinal tract.
[18] A medication for the treatment of hypertension.
[19] Used to measure fluid input and output.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

RN D telephoned Mr A's wife to update her about the GP visit. However, there is no record that Mr A's family were told about the norovirus outbreak.

38. RN C told HDC that prior to the norovirus outbreak he was not aware that Mr A was incontinent. RN C said that on 15 Month14, he gave instructions to staff to keep Mr A's groin clear of faeces, and to apply Menalind cream[20] to the area after each wash. RN C stated: "[A]s [Mr A] was hospital level care it would have been expected practice that he was on a regular toileting regime regardless of this issue being identified."

39. In response to the provisional opinion, RN C told HDC that when Karadean staff and residents were affected by the norovirus outbreak in Month14, the staffing levels were inadequate, and this compromised his ability to meet his responsibilities. RN C also told HDC that he accepts that a continence review ought to have been conducted in Month14 following the norovirus outbreak.

40. Karadean told HDC:

> "It is evident following the review of [Mr A's] file there was a gap in managing his symptoms. The registered nurses and [RN C] have failed in our opinion to ensure an adequate fluid balance was maintained, regular observations of blood glucose was unsatisfactory. The expected standard of nursing practice has not met our expectations."

41. Mr A's family told HDC that there were many instances when Mr A was not being showered, and that his continence pads were not changed frequently when he was incontinent of faeces and urine.

Diabetes and podiatry management

42. Mr A had a diagnosis of Type 2 diabetes. The RLP[21] records that Mr A was to "maintain [blood glucose levels (BGLs)] between 4–12 [mmol/L]", and that he was to be reviewed by a podiatrist if required. The Health Monitoring Records state that Mr A's BGL was taken by staff "as needed".

43. RN D told HDC that Mr A's diabetes was monitored on a regular basis, and that Mr A had yearly profile checks and six-monthly HbA1c blood tests.[22] She stated that the GP advised that blood glucose tests were indicated when Mr A was unwell.

44. Between 12 Month2 and 29 Month10, staff recorded Mr A's BGLs on four occasions, and the levels recorded were between 4–12mmol/L as per his care plan. However, on 9 Month13, Mr A's BGL was 14.8mmol/L — outside the recommended range in his care plan.

[20] A barrier cream used to protect the skin.
[21] Two years prior to these events.
[22] Measurement of the amount of blood sugar attached to haemoglobin (a protein found in red blood cells). HbA1c tests were performed on three occasions.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

45. On 31 Month2 and 9 Month5, a podiatrist reviewed Mr A, and it is documented that no concerns were identified.

46. On 24 Month6, a nurse recorded that Mr A's right big toe was red and swollen, and RN D was informed. RN D reviewed Mr A's toe and advised a nurse to inform the GP owing to concerns that the toe was infected and because Mr A had diabetes.

47. On the same day, Mr A was reviewed by a nurse specialist at a medical centre and prescribed Augmentin[23] and Epsom salts soaks twice daily, and a review with a podiatrist.

48. There is no record in the clinical notes of any podiatry review as recommended by the nurse specialist at the medical centre. RN D acknowledged that there was a delay in arranging a podiatric review because Mr A was seen at the medical centre just before a public holiday. She stated that staff informed the GP that Mr A's toe was improving. Between 25 and 27 Month6, it was documented that Mr A's right toe was improving and that this was communicated to the medical centre.

49. On 29 Month6, the clinical notes record that the redness on Mr A's right toe had resolved. Mr A was seen by a GP the following day, and no change of treatment is noted. The infection care plan on 5 Month7 indicates that Mr A's toe infection had resolved.

50. On 22 Month7, a GP at the medical centre reviewed Mr A owing to concerns by staff that his right toe was infected again. The GP recorded, "paronychia[24] again R[ight] big toe," and prescribed flucloxacillin[25] for one week and requested that a podiatrist review Mr A at the next visit.

51. A podiatrist reviewed Mr A on 22 Month8, and it is recorded that he required a Betadine[26] wipe on his next shower day.

52. An appointment with the podiatrist was scheduled for 23 Month11, but Mr A did not attend, and no reason was recorded.

53. RN D told HDC that Mr A was seen regularly by a podiatrist in accordance with his care plans. However, she acknowledged that Mr A's Long Term Care Plans dated two years prior to these events and 28 Month10 did not record a specific time frame for podiatric reviews, which is appropriate care for a diabetic.

[23] An antibiotic.
[24] Inflammation of the skin around a fingernail or toenail.
[25] An antibiotic.
[26] An antiseptic.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

54. On 23 Month12, Mr A had an HbA1c test,[27] and the GP discontinued Mr A's gliclazide[28] and advised that given Mr A's age and co-morbidities, his diabetes would be managed with diet only.

55. On 4 Month13, Mr A was seen again by a podiatrist. No further podiatric reviews of Mr A were recorded during his time at Karadean.

56. On 15 Month14, Mr A was reviewed by Dr E, who recorded that Mr A was suffering from gastroenteritis and dehydration.

57. At 9.45am on 15 Month14, a CAP student nurse[29] took Mr A's vital signs and BGL, and recorded: "[T]emperature 36.0, pulse 84, respiratory rate 20, blood pressure 120/72, oxygen 96%, blood glucose level 25.7mmol[30]." This blood glucose reading is well outside the recommendation in Mr A's care plan of 4–12mmol/L. It is not recorded whether the student nurse reported Mr A's high BGL to senior staff, or whether a BGL was taken again.

58. At 2.50pm on the same day, RN G recorded: "[C]hecked obs[ervations]. Noted b[lood] p[ressure] 120/72mmHg. Given his BP tablets."

59. Over the following days, multiple nursing staff took Mr A's vital signs, but there is no evidence that any further BGL readings were taken.

60. RN C, the Clinical Services Manager at this time, told HDC that he has no recollection of Mr A's high BGL on 15 Month14. He recalls that RN D was responsible for supervising the CAP nurse who performed the BGL reading that day.

61. RN D stated that she does not recall being advised of the BGL reading on 15 Month14, and believes that another nurse was supervising the CAP student nurse that day. She said that she was present on the GP rounds that morning when the BGL was taken, and that had she been told, then the GP would have commented on this. RN D stated that she was not always responsible for overseeing the CAP student, and that as Clinical Services Manager, RN C also had oversight of the CAP student.

62. In response to the provisional opinion, RN D told HDC that RN C delegated another registered nurse to supervise the CAP student on 15 Month14. Also in response to the provisional opinion, RN C stated that it is unsurprising that RN D has a different recollection to him about who was responsible for the supervision of the CAP student nurse, given the passage of time following these events.

---

[27] A routine blood test to indicate how well diabetes is being controlled.
[28] A medication used to treat Type 2 diabetes.
[29] A Competence Assessment Programme for NZ registered and enrolled nurses who have been out of practice for five years or more and are required to complete the programme before they can be issued with a practising certificate from the Nursing Council of New Zealand.
[30] A normal BGL range is 4.4–8mmol/L.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

63. With regard to the high BGL recorded on 15 Month14, Karadean told HDC:

> "There is no evidence this was escalated to senior staff or even repeated again shortly after the first reading. This demonstrated lack of oversight of the CAP student during this time by the clinical services manager and registered nurse [RN D] who was overseeing the CAP student on that day."

64. Karadean acknowledged that the ongoing care of Mr A was compromised and that the regularity of staff taking his BGLs was inadequate. It said that at the time of events, the UCG policy relating to diabetes management did not outline the frequency of taking BGLs.

Delayed dose of medication

65. On 9 Month13, Mr A complained to staff that he had chest pains, and at 12.50pm he was transferred by ambulance to the public hospital. He was diagnosed with NSTEMI[31] and discharged back to Karadean on 11 Month13. The hospital discharge summary reports that he was prescribed a low dose of metoprolol[32] ("23.75mg daily") in addition to his usual medications.

66. Mr A returned to Karadean at approximately 4.30pm. RN G documented that she reviewed Mr A's hospital discharge summary and noted that no special follow-up cares were required and that Mr A had been charted a new low dose of metoprolol. RN G recorded that another nurse administered Mr A's medication with dinner that evening.

12 Month13

67. At 10.15pm on 12 Month13, RN G documented that during the medication round Mr A had complained of chest pains. RN G took Mr A's observations and recorded:

> "… B[lood] p[ressure] high [179/93mmHg], noted metoprolol not given in the morning as charted daily. Rang [RN C], advised to ring [specialist]nurse [at the medical centre].[33] Verbal order given by [Dr F] for GTN spray[34] 1–2 puffs. Metoprolol given as per discharge summary."

68. A further record stated:

> "[Blood pressure] rechecked prior to administering GTN spray, B/P = 200/100, chest pain 5/5, 1 puff given, metoprolol given. Pain down to 3/5, another GTN 1 puff given sublingually. As per [Mr A], pain getting better, noted O_2 sats dropping to 90%, O_2 2 l[itres] started as per v[erbal] o[rder] aiming for 95%."

69. Mr A's observations were taken on seven occasions, and the last observations at 9.46pm recorded: "[Blood pressure] = 149/81, O_2 sat[urations] 96%, on 2 L[itres] O_2, O_2 changed to

[31] A type of heart attack.
[32] Treatment for heart conditions such as angina and high blood pressure.
[33] RN H — a nurse specialist from the medical centre.
[34] A treatment for acute angina.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

1 L[itre], O_2 sats 95%." RN G recorded that Mr A reported that he was free from any pain and was comfortable.

70. RN G documented:

> "Nurse not happy with metoprolol not given in the morning, advised to complete an incident form. Spoke to CSM [RN C] that metoprolol charted O[nce] D[aily] and if still need to complete an incident form, said if its daily, it is usually given in the morning, and said its fine, he will f[ollow] u[p] with [morning] RN tomorrow and there is no need to complete an incident form. Family to be informed by [morning] RN. Handed over care to night RN. [Mr A] comfortable when last seen. On GP's book to sign v[erbal] o[rder]."

71. RN C stated that on 12 Month13 a registered nurse informed him of the incident. RN C said that he understood from the nurse that a nurse specialist from the medical centre had been consulted and had advised to administer metoprolol that evening. RN C stated that he instructed a nurse to place a request in the GP book for GP review and sign-off of the verbal order of metoprolol, but did not give instructions to complete an incident form. RN C said that on the following day he ensured that Mr A was seen by a GP, and that the GP was informed about the events on 12 Month13.

72. RN C acknowledges that an incident form should have been completed in respect of the delay in administering Mr A's medication on 12 Month13. RN C said that the pharmacy should have been contacted earlier to obtain a copy of the prescription for metoprolol, and that this caused the delay in administering the medication.

73. On the morning of 13 Month13, Dr F reviewed Mr A and noted his recent NSTEMI and that a nurse specialist from the medical centre had telephoned the previous day regarding Mr A's high blood pressure and shortness of breath. Dr F examined Mr A and recorded his impression of "? low oxygen saturation due to L[eft] V[entricular] F[ailure]". Dr F advised to continue oxygen treatment, and discussed Mr A's wishes should his health deteriorate. In accordance with UCG's "Medication Management System Policy" for the verbal orders given on 12 Month13, Dr F charted on Mr A's medication profile 23.75mg of metoprolol daily with breakfast, GTN spray, 2 puffs every 10 minutes as required for angina, and 1–6 litres of oxygen for 24 hours as required.

74. On the same day, a nurse documented: "[N]oted no evidence re informing family re chest pain last night as per handover." The nurse recorded that she telephoned Mr A's wife and informed her about Mr A's condition and the delayed morning dose of metoprolol on 12 Month13.

75. RN C told HDC that on 13 Month13 he told Dr F that on the evening of 12 Month13 Mr A had complained of chest pains and was administered a late dose of metoprolol. RN C said that he asked Dr F to telephone Mr A's family because the GP had frequent contact with the family.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

76. RN C did not record in the clinical notes of 13 Month13 any discussions with Dr F about Mr A's condition. Dr F told HDC that he has no recollection of any discussions with a nurse about a delayed dose of metoprolol on 12 Month13.

77. Karadean acknowledged that if Mr A had not had chest pain on 12 Month13, "it is most likely that the [metoprolol] dose [would have been] missed totally". Karadean considers it highly likely that RN C did not adhere to the medication management policy in regard to the medication error on 12 Month13.

Pressure area and pain management

78. Mr A's RLP was reviewed on 17 Month1, and the section "Skin Integrity Care" recorded that Mr A's skin integrity remained intact and that he continued to receive assistance with skin care.

79. A review of the RLP on 21 Month4 noted that Mr A's skin integrity would be monitored and maintained. A multi-purpose form was commenced to document any bruises.

80. Between Month4 and Month14, Norton scale risk assessments[35] (Norton assessments) were performed three monthly. Mr A initially scored 18 (a score of 14 or lower indicates that a resident is at risk of developing a pressure area). His score remained unchanged for the rest of his Norton assessments despite deficits in his physical and mental condition, activity, mobility, and incontinence being noted in his clinical notes and care plans.

81. Between Month5 and Month13 Mr A was reviewed by a GP every three months,[36] and had several consultations relating to a change in his health.[37]

82. On 3 Month7, a nurse documented that Mr A's groin appeared very red, but that no pain was present. A Short Term Care Plan was commenced and it directed staff to perform daily checks of Mr A's groin, keep this area dry and clean, and apply Cavilon cream.[38]

83. On 6 Month7, a nurse recorded that a GP had prescribed Micreme[39] as required for redness to Mr A's scrotum. It was not recorded whether the GP reviewed Mr A personally.

84. Between 3 Month7 and 3 Month8, staff reviewed Mr A's groin and scrotum regularly, and documented that the area required careful washing and drying.

---

[35] The Norton assessment is a predictive tool for assessing the risk of developing pressure areas. The assessment evaluates physical condition, mental condition, activity, mobility, and incontinence, to give a score between 5 and 20. A lower score indicates a higher risk of developing a pressure area.
[36] GP reviews took place on 2 Month5, 17 Month8, 4 Month11, 22 Month12, and 25 Month13.
[37] GP consultations took place on 26 Month6, 30 Month6, 22 Month7, 13 Month10, 27 Month11, 13 Month13, 22 Month13, 15 Month14, and 18 Month14.
[38] A barrier cream.
[39] A broad-spectrum anti-fungal and anti-inflammatory cream.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

85. On 22 Month7, a GP reviewed Mr A owing to concerns that his right toe was infected again (see paragraph 50). There is no evidence that the GP was asked to review Mr A's groin or scrotum on this occasion.

86. On 26 Month7, a nurse recorded in the RLP: "Mr A had episodes of further infection on groin/scrotum area. Managed by prescribed cream [Micreme]. Perineal hygiene promoted." There is no evidence of any further GP review of Mr A's pain or redness of his groin and scrotum. On the same day, Mr A's Norton assessment was reviewed and remained unchanged from the previous assessment on 18 Month4.

87. Between 4 Month8 and 17 Month14, the caregivers and registered nurses intermittently recorded on 31 occasions[40] that Mr A's scrotum and groin were red. It was also documented on multiple occasions[41] that Mr A had reported pain in the scrotum or groin area, in particular when he was being assisted with showering. The clinical notes record that on multiple occasions Cavilon cream was applied to Mr A's scrotum and groin area, and that the area was to be washed and dried carefully. Occasionally it was recorded that the caregiver would report Mr A's redness or pain to the registered nurse.

88. On 27 Month8, a pain monitoring form was commenced because Mr A had a sore scrotum, for which paracetamol was given.

89. A review of Mr A's RLP on 28 Month10 noted that moisturiser was to be applied to his groin and scrotum area as needed. A review of Mr A's skin integrity noted that he had a pink/red bottom but no skin breakdown, and that Cavilon cream was to be applied as required.

90. On the same day, Mr A's Norton assessment was updated. The Norton scale score identified Mr A's potential risk of pressure injury as 18, and unchanged from the previous assessment in Month7.

91. On 28 Month10, a Short Term Care Plan stated that a pressure-relieving air mattress would be obtained to prevent pressure areas developing. However, there is no documentation of an existing pressure injury at this time and an air mattress was not obtained during Mr A's time at Karadean. In response to the provisional opinion, RN D stated that she has no recollection of the Short Term Care Plan recorded on 28 Month10.

92. On 29 Month10, a pain monitoring form recorded that Mr A declined analgesia[42] for his sore bottom, and that he would be offered analgesia later that day.

93. RN D told HDC that on most occasions, Micreme cream or spray was effective in resolving Mr A's redness and settling his soreness, in addition to continence care and timely toileting. She said that Mr A was offered analgesia at times, but he declined it. However, she

[40] 6 x Month7, 9 x Month8, 4 x Month9, 4 x Month10, 1 x Month11, 3 x Month12, 4 x Month14.
[41] 26 Month8, 27 Month8, 16 Month9, 16 Month10, 17 Month10, 24 Month10, 03 Month12.
[42] Pain relief medication.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

acknowledged: "[W]e should have utilised his PRN[43] analgesia more effectively on [the] occasions he reported pain."

94. In Month11 and Month12, staff recorded on four occasions that Mr A's scrotum was pink in colour, and that fatty cream[44] was applied to the area.

95. In Month13, there were no incidences recorded of Mr A complaining about any pain related to his scrotum or groin or staff noting any concerns about this.

96. A review of Mr A's pressure area risk on 2 Month14 recorded a Norton score of 18, and noted that it was unchanged from the previous assessment in Month10.

Norovirus outbreak

97. On 13 Month14, a caregiver documented: "[S]kin breakdown and redness of [Mr A's] bottom noted, notified the RN." There is no record that a registered nurse reviewed Mr A's skin breakdown that day. However, Karadean told HDC that the registered nurse was unable to review Mr A's reported skin breakdown that day because of inadequate staffing levels, as an outbreak of norovirus had caused the absence of four registered nurses. Karadean said that usually the nurse worked at another facility within the group, and was not familiar with the residents at Karadean. The nurse was responsible for the medication round, and that afternoon another resident passed away.

98. RN C told HDC that on a number of occasions he personally covered the role of the night shift nurse while maintaining his role as the Clinical Services Manager during the day, because Karadean had no arrangement for temporary staff for afternoon or overnight shifts.

14 Month14

99. At approximately 7am, RN I reviewed Mr A's bottom, as requested by the caregiver the previous day. RN I documented:

> "Broken area around natal cleft measures ± 2cm long. Dark circular areas both sides of broken areas both sides of broken area. Covered raw area [with] flexifix.[45] Turning to R[ight] to L[eft] 4 [hourly] overnight. [Mr A] in pain when put on his back … still having diarrhoea overnight. Completed incident form for pressure area. Handed over to the am RN for follow up [and to] complete necessary documentation."

100. At 10am, RN G dressed the sacral wound and completed a Soft Tissue Care Plan, a Short Term Care Plan, a Wound Care Chart, and a Pressure Injury Assessment and Management Plan, in accordance with UCG's policy entitled "Assessment and Management of Pressure Injury Risk".

[43] As needed.
[44] A moisturiser for dry skin.
[45] A transparent adhesive film that allows the fixation of dressings.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

101. The Soft Tissue Care Plan recorded in particular: "Pain 2/5, Blood Oozing none, Slough [46] none, Necrosis[47] 50%, Colour black/red, Temperature normal to body, Surrounding skin red and fragile."

102. The Pressure Injury Assessment and Management Plan directed the person who dressed the wound to record notes in the sections "treatment plan" and "dressing products", but these sections were blank.

103. The Short Term Care Plan directed that Mr A was to be washed and dried twice daily, and the skin breakdown at the natal cleft was to be dressed daily.

104. RN G took a photograph of Mr A's sacral wound and discussed it with RN C. However, the photograph was not retained in Mr A's clinical records. RN C stated that he assumed that the photo was printed and included with Mr A's documentation. RN C said that his usual practice is to take a photo of a wound and include a copy in the pressure area treatment plan, but that he asked RN G to delete the photo because it was taken on her personal device. In response to the provisional opinion, RN C said he believed that RN G had printed a copy of the photo for the file.

105. Karadean told HDC that RN G and RN C discussed the "legality of keeping a photo of the wound", and decided to delete the photo. Their recollection is that the sacral wound was black, indicating necrosis. Karadean also told HDC that on 14 Month14 the sacral wound was unstageable,[48] with 50% necrosis.

106. RN C told HDC that he discovered Mr A's ankle pressure area on 14 Month14. RN G documented that Mr A's right foot was "mild pink", and that pillows were placed under his leg so that his foot was not in contact with the bed. RN G also recorded that the turning chart was maintained, which directed that Mr A be turned every two to three hours and a pillow placed under his ankle, and that he not be placed on his back.

107. RN G documented that at 10.20am she reviewed Mr A and took his observations, and found that his blood pressure was 60/40mmHg. At 10.30am, Mr A's blood pressure was recorded as 100/60mmHg, and at 2.35pm it was noted to be 90/60mmHg.

108. At 3.50pm, RN G recorded in the clinical notes that Mr A had had loose bowel movements 5–8 times, was not taking any food, had vomited that morning, and that caregivers had noted that Mr A's lips were blue. At 4pm, RN G recorded in the Relative Contact Record that Mr A's wife had been informed about Mr A's pressure injury and his low blood pressure.

109. On the evening of 14 Month14, Mr A was reviewed regularly by a nurse, who noted that his appetite was poor and that food and fluids were encouraged. The nurse stated that she

[46] Dead tissue that has separated from the wound.

[47] Dead tissue.

[48] Full thickness tissue loss in which the base of the pressure injury is covered by slough (yellow, tan, grey, green, or brown) and/or eschar (tan, brown, or black) in the pressure injury bed.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

cannot recall the presentation of Mr A's pressure wound at the time of events. She said that she was due to commence her orientation that week, but was unable to because of the staff shortages following the norovirus outbreak.

15 Month14

110. At 2am on 15 Month14, a caregiver recorded in the clinical notes that Mr A's bottom was red and that a registered nurse had been notified.

111. At 7.15am, RN I reviewed Mr A and recorded that he had a red area around the anus related to his diarrhoea, and that his sacral pressure area had remained intact overnight.

112. That morning, Dr E reviewed Mr A at Karadean in relation to his norovirus symptoms.[49] RN D was present when Dr E conducted her rounds, but did not report Mr A's pressure wound to her. There is no evidence that Dr E was advised about Mr A's frequent faecal incontinence or ankle pressure injury on this occasion.

113. RN D told HDC that on 15 Month14 she had returned to work after two days on leave. She said that she was not aware of Mr A's sacral pressure area, and this was not recorded in the GP review form.[50] RN D said that during the GP rounds she relied on the information recorded in the GP review form. Karadean was unable to provide HDC with the GP review forms relevant to the events in this investigation.

114. RN C acknowledged that the sacral pressure injury should have been reported to a GP. He said that on 15 Month14, he asked RN D to inform the GP about Mr A's sacral pressure wound, and that there was sufficient documentation about the pressure injury available to alert RN D to the issue. RN C stated that he was entitled to rely on the registered nurses ensuring that they were familiar with a patient's clinical notes when accompanying a GP on rounds.

115. In response to the provisional opinion, RN D reiterated that she relied on the GP review form, which she said did not mention Mr A's sacral pressure area. She also stated that she has no recollection of any instructions from RN C to inform the GP about Mr A's sacral pressure area. RN D said that when she arrived to commence the GP round, RN C was in the office with the GP.

116. At 2.50pm, RN G reviewed Mr A and recorded that she had dressed his sacral wound and that the wound treatment chart was yet to be evaluated by RN C.

117. A registered nurse recorded on the Soft Tissue Care Plan that the wound was black in colour and the surrounding skin was red and fragile, and that the wound had 50% necrosis and no slough.

---

[49] See para 36.

[50] Nurses record on the GP review form the name of the residents who are for review by the GP. The form is reviewed by the Clinical Services Manager prior to the GP's review.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

118. RN D telephoned Mr A’s wife and updated her on the GP’s visit, Mr A’s blood pressure, and his commencement of food and fluid, but she did not report on his sacral wound.

119. On 15 Month14, RN C reviewed the Pressure Injury Assessment and Treatment Plan and the Short Term Care Plan. He rated the sacral pressure wound as stage 2.[51] He noted a further pressure area on Mr A’s right foot and recorded this in the Short Term Care Plan. He recorded in the clinical notes:

“• Grade two pressure injury noted.
- Short term care plan commenced.
- An alternating air mattress will be ordered if the pressure injury worsens.
- Dressing daily to monitor progress and 3–4 hourly turns.
- Apply Menalind cream to scrotum/groin to area after each wash.
- Redness noted on [Mr A’s] right foot. Pressure relief heel booties applied and a pillow placed under the right ankle area.”

120. RN C acknowledged to HDC that a separate care plan for the new pressure area on Mr A’s right foot would have been preferable. In response to the provisional opinion, RN C stated that because the right heel redness was blanchable, it “would appear not to have met the criteria for a stage one pressure injury which is ‘non blanchable redness’”. He stated that he was first informed about the sacral pressure injury on 15 Month14, and he reviewed the wound that day. He said that a treatment plan was in place, and that he requested an air mattress from a manager, because no air mattresses were available at Karadean. In response to the provisional opinion, RN C told HDC that he made further requests to another manager for an air mattress. RN C said that at handover on 15 Month14 he gave instructions to staff about the management of Mr A’s pressure areas, recorded the details of his plan in the progress notes, and ensured that the information was included in handovers to all nursing staff.

16 Month14

121. On 16 Month14, RN G re-dressed and evaluated the sacral pressure wound. She commenced a wound treatment chart and recorded that the wound was 4.0cm x 0.2cm, superficial depth[52] with black necrotic eschar,[53] black epithelialising[54] wound margins, and granulating tissue.[55] RN G recorded on the Soft Tissue Care Plan that necrosis was present but there was no slough, and the surrounding skin was pink.

[51] UCG’s policy “Cause and Description of Pressure Injuries” describes a stage 2 wound as partial thickness skin loss, a break in the epidermis (skin), and a shallow open wound that may appear as an abrasion, blister, or shallow crater.
[52] Limited to the outer layers of skin.
[53] Dry, thick, leathery tissue.
[54] The wound surface is being covered with new tissue.
[55] Healthy tissue formed during healing.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

122. The turning chart for 16 Month14 recorded that caregivers turned Mr A on four occasions, and that his bottom was red.

17 Month14

123. On 17 Month14 at 3.50pm, RN G evaluated and re-dressed Mr A's sacral wound. She recorded in the wound treatment chart that the wound was unchanged, and had superficial depth, black necrotic eschar, black epithelialising wound margins, and granulating tissue. She recorded on the Soft Tissue Care Plan that the wound was black and the surrounding skin red, and that there was 40% necrosis and no slough.

124. At 5pm, another nurse recorded that Mr A's sacral wound dressing had been changed.

125. RN C reviewed the Pressure Injury Assessment and Management Plan and recorded that the pressure injury rating was unchanged and "grade 2".

126. Mr A's turning chart recorded that he was turned on 10 occasions, and that his bottom was red.

127. That evening, a caregiver noted that she had notified a registered nurse that Mr A's scrotum was red. However, there is no documentation that this concern was followed up by a registered nurse.

18 Month14

128. Dr E reviewed Mr A on 18 Month14 in relation to changes in his blood pressure medication. Dr E recorded that Mr A's blood pressure and heart rate were normal, and that he was recovering well from gastroenteritis. There is no record that Dr E was advised about Mr A's sacral wound or ankle pressure areas.

129. RN D was present during the GP rounds on 18 Month14, but did not inform Dr E about Mr A's sacral wound. She told HDC that she did not personally sight Mr A's sacral wound because RN C had told her two days earlier that he was "sorting" Mr A, and that "it was not her problem". RN D reiterated that she was guided by the information on the GP review form. In response to the provisional opinion, RN D told HDC that when she arrived to commence the GP round on 18 Month14, again RN C was in the office with Dr E. She further stated that she has no recollection of RN C instructing her to inform the GP of Mr A's sacral pressure area.

130. RN D acknowledged that she should have told the GP about Mr A's sacral wound, but noted that it was recorded by staff as "superficial" between 16 and 20 Month14. She recalls that it was a busy week at Karadean, and that only two GP rounds were conducted instead of the usual three, and that there was a norovirus outbreak at the time.

131. RN C told HDC that on 18 Month14 he gave instructions to RN D to inform the GP about Mr A's pressure areas, and he does not know why this did not occur. He refutes RN D's statement that he said he was "sorting out" Mr A and that "it was not her problem". In response to the provisional opinion, RN C further stated that he considered that there was

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

ample information available to RN D in the progress notes, handover sheets, short-term care plan, and pressure injury management plan when she accompanied the GP on the rounds in Month14.

132. The clinical notes for 18 Month14 record that a pillow was placed under Mr A's heels to relieve pressure, and that he was turned every four hours. His turning chart notes that he was turned on nine occasions, and that his bottom and scrotum were red.

133. On 18 Month14, RN G evaluated and re-dressed Mr A's sacral wound. She recorded in the wound treatment chart that the wound was unchanged, with superficial depth, black necrotic eschar, red granulating tissue, and mildly pink wound margins. She noted in the Soft Tissue Care Plan that the wound was mild pink in colour with red surrounding skin and no necrosis or slough. RN G did not record in the progress notes that Mr A's wound was redressed and evaluated.

134. On the same day, RN C reviewed the sacral wound and recorded in the Short Term Care Plan:

> "… Dressing done. Noted black/brownish 5–9% of pink red wound bed. Pink/red 90% wound bed. Nil slough noted. Same size as previous. Surrounding area non-blanchable redness. Grade 1 pressure ? related to loose bowel motions? Faecal burn. Dressing to be reviewed if soiled [with] faeces."

135. On 19 Month14, it was recorded that Mr A continued to have vomiting and diarrhoea, and that caregivers turned him onto his left side, right side, and back, and that his bottom was not red.

136. RN C reviewed the Pressure Injury Assessment and Treatment Plan and recorded that the sacral wound remained unchanged at "grade 2". There is no record in the wound treatment chart, Soft Tissue Care Plan, or clinical notes that Mr A's sacral wound was reviewed.

137. On 20 Month14, RN G evaluated and re-dressed Mr A's sacral wound, and recorded in the wound treatment chart that the wound was unchanged, 4–5cm, superficial, with necrotic eschar, pink epithelialising tissue, red granulating tissue, and mildly pink wound margins. She updated the Soft Tissue Care Plan, but did not complete the "evaluation" section, and no further wound updates are recorded in the Soft Tissue Care Plan.

138. The turning chart for 20 Month14 records that caregivers turned Mr A on 10 occasions.

139. At 6.20am on 21 Month14, RN I recorded that the sacral wound dressing was intact. RN G evaluated and re-dressed Mr A's sacral wound, and recorded in the wound treatment chart that the wound had increased in size to 5.0cm x 5.0cm, and the necrosis had increased to 70% with 30% slough. The progress notes do not record whether the Clinical Services Manager or GP were informed of the wound deterioration.

140. RN G acknowledged that she did not measure the pressure injury on 21 Month14.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

141. The turning chart for 21 Month14 records that caregivers and nurses turned Mr A on seven occasions.

142. Karadean acknowledged: "[W]e have failed to meet the expected standard of care required for complex wound management such as pressure injuries. [There is] also gross departure from clear precise documentation."

Transfer to the public hospital

143. At 5.20am on 20 Month14, RN I recorded that Mr A appeared very frail. At 2.50pm, RN G noted that Mr A had sustained a fall at 8.45am, and that she had assessed him for injuries but found none. RN G completed an incident form and informed Mr A's family and RN C of the fall.

144. At 10.30am on 21 Month14, a caregiver noted that Mr A's right cheek was swollen, and a registered nurse was notified. The nurse reviewed Mr A and noted that his right cheek and the inside of his mouth were swollen and painful, but the area did not feel hot and there was no redness. RN C was informed of the injury. Mr A's observations at 7.30am were noted to be normal except for his blood pressure, which was 170/87mmHg. Mr A's observations were taken again at 11.00am, after the medication round, and his blood pressure was recorded as 134/74mmHg. A nurse telephoned RN H, who agreed to attend Karadean to review Mr A.

145. The Relative Contact Sheet records that at 11am on 21 Month14 a nurse telephoned Mr A's wife and reported that Mr A had a swollen cheek and was "really weak and tired", and advised that she could visit Mr A that day if she wished.

146. RN H attended Karadean at 11.45am to review Mr A. She recorded: "1–2 hour hx [history] right facial swelling. Tender on palpation." She noted that his cheek was not warm, there was no erythema, and there was no obvious stone in the parotid gland[56] duct. Mr A's observations were taken, and noted to be within his normal range. RN H's impression was of a probable parotid gland obstruction, and she advised staff to apply a warm compress and administer regular paracetamol for pain, and to commence a fluid balance chart and offer Mr A an Enerlyte supplement.[57] She also recorded that she would review Mr A that afternoon.

147. RN H reviewed Mr A again at 3pm, and recorded that his temperature was 37.9°C. She discussed Mr A's condition with Dr E, who advised to commence a seven-day course of antibiotics[58] for a suspected parotid gland infection. RN H documented that staff were to take further observations and encourage Mr A's fluid intake, and that the GP would review Mr A in the morning.

[56] Salivary gland.
[57] Fluid and electrolyte replacement used to treat gastroenteritis.
[58] As recorded on the resident medication profile.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

148. At 4pm, RN J noted that Mr A was very tired but responding to sounds. RN J made two unsuccessful attempts to give Mr A his oral antibiotics. She telephoned Mr A's wife about a possible hospital admission for intravenous antibiotics, and the family gave consent for transfer to hospital. RN J consulted with RN H, who advised to transfer Mr A to hospital. RN C was informed, and an ambulance was called. Mr A had two episodes of vomiting.

149. Karadean told HDC:

> "[I]t is not uncommon for elderly residents whose general health is deteriorating to not be able to tolerate oral antibiotics, there is a question with regards to whether the antibiotics should have commenced or attempted to commence earlier than prescribed."

150. RN J prepared Mr A's Transfer Referral Report, which accompanied him to hospital. The report recorded Mr A's primary diagnoses of hypertension, hypothyroidism, ischaemic heart disease, stroke, Type 2 diabetes mellitus, and vascular dementia. The section "activities of daily living" noted that Mr A was incontinent of bowel and bladder. The section "pertinent history" noted "see list". Mr A's facial swelling, sacral wound, ankle pressure, and scrotal redness and pain were not recorded in the Transfer Referral Report.

151. Mr A was transferred to the public hospital by ambulance at 6.30pm, and admitted to the Emergency Department at 8.13pm. He was assessed by the Emergency Medicine Team and diagnosed with parotitis and sepsis. It was recorded that Mr A had "large pressure sores over his sacrum, [and] necrotic tissue". He was transferred to a ward.

Subsequent events

152. Mr A was reviewed on 22 Month14, and his sacral wound was described as "huge" and in need of specialist wound care or surgical debridement.

153. On 22 Month14, RN K[59] at the DHB was asked by hospital staff to review Mr A following concerns about his unreported necrotic sacral pressure injury. RN K telephoned RN C to enquire about the care that had been provided for Mr A's pressure injury. RN K recorded that RN C stated that Mr A had been turned every 2–3 hours and that a pressure-relieving air mattress had been ordered but he was awaiting approval by Karadean management. RN K asked RN C why the transfer notes that accompanied Mr A to hospital did not record his sacral pressure injury, and RN C advised that this was an oversight by the nurse at the time.

154. On 23 Month14, RN K documented that he received a telephone call from the Facility Manager at Karadean, who advised that management approval was not required to obtain a pressure-relieving air mattress, and that these were available from other UCG facilities at any time.

155. RN C told HDC that he has no recollection of any discussion with a nurse at the DHB about the requirements to obtain a pressure-relieving air mattress. Furthermore, he considers it

[59] A transfer of care nurse.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

unlikely that he would question the necessity for a pressure-relieving air mattress given that he had noted his intention to obtain one on 15 Month14.

Staffing levels and training

156. Mr A's family told HDC that initially they were satisfied with the care Mr A received, but that over the last few years of his residency it became apparent that there were issues with staffing levels and the quality of staff at Karadean.

157. RN D told HDC that during her time as the Clinical Services Manager she was concerned about the skill mix of the registered nurses. RN D stated: "[T]he RNs were junior and/or inexperienced in aged care and required a lot of support and guidance which I was happy to provide and did so on a daily basis."

158. RN D said that she had reported her concerns about the lack of experienced nurses to the Facility Manager, and on several occasions to UCG. She stated that in Month6 she was told by UCG that experienced nurses would be sought for Karadean, but this did not happen. She told HDC:

> "[In Month9 I attended a UCG Manager's Meeting and reported my concerns about] our junior inexperienced RN team at Karadean and how concerned we were especially me as I was CSM at how something may go wrong and how hard it was becoming to oversee care delivered. Once again NSO [UCG] promised they would support us in getting experienced RNs till the day I stepped down [as Clinical Services Manager] it never happened."

159. In response to the provisional opinion, RN D told HDC that she was advised by the Facility Manager that she was not to orientate RN C to the role of CSM, and that this direction came from the National Support Office.

160. RN C told HDC that he was dissatisfied with the level of training and support he received in his first few months as Clinical Services Manager. In particular, he said that the support from a number of managers was unsatisfactory to support his orientation.

161. RN C stated that at the time of the events, the nursing staff skill mix caused resourcing issues. He said that when he commenced the role as Clinical Services Manager, Karadean was two nurses short, and during his time at Karadean there was a high turnover of caregivers and nursing staff.

162. RN C said that he was one of two registered nurses providing oversight to the inexperienced nurses, who included one novice nurse with fewer than two years' experience, new graduates with under a year of experience, and nurses who had just finished the competency assessment programme. He stated that he was required to provide high levels of supervision of staff, and that he had insufficient time to attend to the responsibilities of Clinical Services Manager. He told HDC: "I raised this often with management and there were ongoing discussions to address the problem with no real changes made during my time at Karadean."

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

163. Karadean told HDC that in Month12, RN C reviewed the skill mix of staff. Karadean stated:

> "It was evident that the facility had two proficient nurses and that was the senior Registered Nurse and the CSM at that time, one competent nurse, three advanced beginners and two novices. It was clear that the skill mix on site at the time of the events was considerably lacking in competent registered nurses with there being over 50% of the registered nurses requiring support in their roles as registered nurses and only two registered nurses who could provide that support … Since then and following staff changes at Ultimate Care Karadean the skill mix in following these events, showed three novice RNs, one advanced beginner and six proficient registered nurses."

Policies

164. Karadean's policies at the time included a "Pain Management Policy", an "Assessment and Management of Pressure Injury Risk", a "Diabetes Policy", a "Deterioration in Health Status Procedure", a "Medication Management System Policy", and a "Clinical Records Documentation Policy". Relevant extracts are included below.

165. The "Pain Management Policy" provides that an assessment should be carried out for a resident who presents with acute/new pain. A short-term care plan or a long-term care plan (resident lifestyle plan) is commenced and evaluated at least every three months. The policy notes that "the causative factors of pain are investigated by the RN and GP as required" and that "regular liaising with the GP occurs to ensure effective pain control is achieved".

166. The "Assessment and Management of Pressure Injury Risk" policy provides that a registered nurse will assess a resident using the Norton scale for pressure injury risk. The nurse will record management plans and interventions in the lifestyle plan and clinical notes. The care team will conduct ongoing monitoring, and assessments will be reviewed every three months and when there is a change in condition. The policy provides that "Pressure injury intervention and evaluation will be as per Best Practice Wound Management", "pressure injuries will be documented on the Wound Assessment and Management Care Chart", the GP is to be notified, the family is to be informed, and the patient is to be referred to a wound nurse specialist if required.

167. The "Diabetes Policy" outlines that if a resident has hyperglycaemia with a blood glucose level above 8mmol/L, the resident is to be given insulin immediately and medical help is to be obtained.

168. The "Deterioration in Health Status Procedure" provides that staff will ensure "timely and appropriate assessment of an identified change in a resident's health status whether due to injury or illness". A registered nurse will assess the resident and may decide to seek medical advice from the resident's GP or the on-call GP.

169. The "Medication Management System Policy" states that all medication errors will be recorded on an incident form, including errors relating to "wrong time, omissions". The policy notes that when an error is reported, the senior nurse and/or the prescriber will be

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

notified immediately, and the resident will be monitored. The resident or activated enduring power of attorney will also be informed. Regarding medication reconciliation, when residents are re-admitted from hospital with a prescription and a discharge summary that needs to be reconciled with the drug chart, the drug chart and the discharge summary are to be faxed to the GP to make the changes, and the amended drug chart is then to be sent to the pharmacy for the medication to be issued.

170. The "Clinical Records Documentation Policy" states that "entries must be factual, accurate, legible and complete", and that "[t]he Clinical Record is a legal document" and "must provide clear evidence of care planning, decisions made, care delivered, information shared, problems identified and actions taken to rectify them".

171. The "Care Plan Policy" states that each care plan focuses on the resident and states actual or potential problems and sets goals for rectifying these or promoting optimal health with detailed interventions required.

172. Karadean referred to the DHB's Infection Prevention and Control Guidelines, which provide guidance and advice for the management of a respiratory outbreak in an aged-care facility.

Further information

RN C

173. RN C told HDC that during his four months as the Clinical Services Manager at Karadean he introduced GP reporting forms and written handover sheets. He further stated that as the Clinical Services Manager he ought to have been in a position to review unwell patients to ensure that concerns had been reviewed by a GP appropriately. However, he said that because of the nursing skill mix, he was unable to attend to all his Clinical Services Manager duties, and that this situation was exacerbated by the norovirus outbreak.

Ultimate Care Group Limited

174. Karadean told HDC:

> "As the clinical manager at Ultimate Care Karadean the CSM [RN C] had responsibility to provide effective clinical leadership to clinical and care staff. [RN C] was required to personally check on critically unwell residents and work through plans of care with the RNs, put in place required monitoring and arrange doctors' input. This clearly did not happen in the case of [Mr A]."

175. Karadean told HDC that owing to the frequency of the GP reviews of Mr A, it considers that he had sufficient GP input into his care during his time at Karadean. However, it acknowledged that it did not meet the expected standard of care, and stated:

> "There has been a significant departure from the expected standard of nursing care by the then clinical services manager [RN C] as well as several registered nurses under his supervision."

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

176. Karadean stated that following this complaint, its designated auditing agency undertook a certification audit in 2017 and a surveillance audit in June 2019. Karadean told HDC that the audits undertaken found no evidence of the recurring issues found at the time of events.

177. In response to this complaint, Karadean told HDC that all pressure injuries are reported to the National Office, and a National Clinical Coach oversees the management of wounds for all residents. In addition, a regional quality nurse advisor provides clinical support to the clinical managers in their region. Karadean also stated that regular audits of clinical documentation, including care plans, are performed by an audit and compliance manager.

178. Karadean told HDC that since these events it has made the following changes:

- It has reviewed its Pressure Injury Prevention and Management Policy.
- It has updated its Cause and Description of Pressure Injuries to reflect the use of the Short Term Care Plan for pressure injuries.
- It has reviewed its Management of Diabetes Policy and added Blood Glucose Monitoring for Type 2 Diabetics.
- It has reviewed its Deterioration in Health Status Procedure to show that Short Term Care Plans are to be instigated if a resident is unwell and is to remain under the management of the facility.
- It has revised its Clinical Communication Tool to include a map of the person, to locate pressure injuries, skin tears, and bruising when making a referral.
- It has revised its Pain Management Policy to place emphasis on pain monitoring and short-term care planning (for acute pain).
- It is developing a Hydration Policy.

Responses to provisional opinion

179. Mrs B, Ultimate Care Group, RN C, and RN D were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into the report.

180. Mrs B told HDC:

> "Someone has to be accountable for not taking care of Dad like they should have done. The level of care wasn't there for Dad when it should have been. If staff had followed things up with the rest home about Dad's care there may have been a different outcome. We know this won't bring Dad back, but we don't want anyone else to go through this."

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

181. Ultimate Care Group told HDC: "We deeply regret the undue stress this complaint may have caused the late [Mr A's] family". It also accepted the recommendations in the provisional opinion.

182. RN C told HDC that he "feels genuinely remorseful that he was unable to be more proactive in managing the level of care [Mr A] was receiving at Karadean". RN C stated that he resigned from his role as the Clinical Services Manager because he no longer felt that the role was professionally safe.

183. He submitted that it was unfair to criticise him for the lack of clear communication regarding who was responsible for supervising the CAP student nurse. He also stated that he has undertaken training in relation to clinical documentation and wound management. RN C said that he has applied to undertake further education on nursing leadership and management.

184. RN D submitted that she has undertaken training in relation to pressure injury prevention, monitoring a deteriorating patient, quality and risk management, clinical leadership, documentation, enduring power of attorney, age-related residential care agreements, and communication.

Relevant standards

Health and Disability Services (Core) Standards — Organisational management NZS 8134.1.2:2008

Service Management

185. Standard 2.2 states: "The organisation ensures the 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."

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

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: The Ultimate Care Group Limited — breach

Introduction

187. The Ultimate Care Group Limited (UCG) had a duty to provide Mr A services with reasonable care and skill, and is responsible for the actions of its staff at Karadean Court. UCG also has a duty to ensure that its staff provide services that ensure continuity of care and comply with the New Zealand Health and Disability Services (Core) Standards (NZHDSS). In particular, I note that NZHDSS Service Management Standard 2.2 states:

> "**Service Management Standard 2.2**: The organisation ensures the 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."

188. Mr A's medical history indicated that he was at risk of developing pressure wounds owing to his incontinence and poor skin integrity. Various staff involved in Mr A's care should have been alert to the changes in his condition and should have reacted more rapidly to his incontinence, pain management, wound care, and diabetes management. Appropriate equipment such as an alternating air mattress should have been readily sourced for Mr A. Care plans should have been reviewed regularly and updated in response to his deteriorating condition, so that all staff involved consistently administered his cares and monitored and reported symptoms.

189. I consider that deficiencies in the care provided by multiple staff represent systemic issues at Karadean. These are outlined below.

Incontinence and diarrhoea

190. Between Month2 and Month14, Karadean staff recorded on multiple occasions that Mr A was incontinent of urine and faeces.

191. Between Month1 and Month14, four continence assessments were performed. In Month1, a continence assessment stated that Mr A was incontinent of urine but not of faeces. In Month7, Mr A's continence assessment noted that he was incontinent during the day and night, but his continence management plan remained "unchanged". In Month10, Mr A's continence was reviewed and his toileting regimen was changed. RN D stated that the interventions taken and the education provided to staff reduced the incidence of incontinence. In Month14, the continence review was unchanged from the assessment in Month10.

192. Mr A's Residential Life Plan was reviewed on 28 Month10 and directed staff to administer laxatives or medication for loose bowel motions, and to monitor bowel motions and assist Mr A when using the toilet.

193. From 12 Month14, Mr A had multiple incidents of diarrhoea and vomiting due to a norovirus infection. A Short Term Care Plan was commenced to monitor Mr A's fluid intake. Three

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

days later, a GP reviewed Mr A and noted that he was dehydrated, and directed staff to encourage fluids and to transfer him to hospital if he remained acutely unwell.

194. My expert advisor, RN Rachel Parmee, stated:

> "Continence care, including diarrhoea, and hydration are expected basic requirements in the care of older adults in a hospital level care setting. These cares should be provided based on regular assessment leading to a documented care plan with regular evaluation and when there are changes in the status of the client.
>
> Continence care includes the implementation of an appropriate, documented, toileting regimen which is adhered to by all involved in the client's care, along with the use of appropriate continence products with regular evaluation of their effectiveness.
>
> Assessment of hydration is integrally linked with continence care particularly in the presence of diarrhoea. Diarrhoea can lead to rapid loss of hydration and should be investigated and treated with medical input if necessary."

195. RN Parmee advised that the continence reviews on 26 Month7, 28 Month10, and 2 Month14 were inaccurate, and indicated that there was no review of the toileting regimen or incontinence products. RN Parmee stated that there is little evidence of review of the interventions and evaluations in response to Mr A's incontinence. She was also critical that during some periods of care there is no evidence of GP advice having been sought to address Mr A's continence issues. RN Parmee advised that the management of Mr A's incontinence was poor, and that the episodes of incontinence contributed to the status of Mr A's skin integrity. RN Parmee considers this to have been a significant departure from the accepted standard of care.

196. I accept RN Parmee's advice. I am highly critical that the continence reviews and care plans did not reflect Mr A's continence needs or guide staff in that care. Multiple staff recorded that Mr A had frequent episodes of incontinence and, despite this, there was no escalation to a GP. In my view, this shows a lack of critical thinking by multiple staff, and a lack of attention to Mr A's needs. In light of Mr A's diabetes and risk of pressure areas, staff should have been alert to his continence and hydration, in particular when he had a norovirus infection. I am critical that this did not occur. In my view, the poor standard of care planning and documentation contributed to the failure of staff to provide appropriate interventions to manage Mr A's continence.

Podiatry and diabetes

197. Mr A was reviewed by a podiatrist on 31 Month2, and was seen a further three times during his residency at Karadean. On 24 Month6, a nurse specialist at the medical centre reviewed Mr A's infected right toe and recommended a podiatrist review. There is no documentation of any podiatric review as requested by the nurse. On 22 Month7, a GP reviewed Mr A and requested a podiatric review, and Mr A was seen by a podiatrist on 22 Month8, some two months after the initial recommendation by the nurse specialist at the medical centre

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

198. An appointment with the podiatrist was scheduled for 23 Month11, but Mr A did not attend, and no reason was recorded. RN D acknowledged the delay in arranging a podiatric review, and said that the delay occurred because of a public holiday. She stated that staff informed the GP that Mr A's toe was improving. RN D acknowledged that Mr A's Long Term Care Plan on 28 Month10 did not record specific time frames for podiatric reviews, which is appropriate for a diabetic.

199. RN Parmee stated: "Foot care is also significant in the care of clients with Diabetes with the potential for diabetic neuropathy." RN Parmee considered that the frequency of podiatry reviews and the documentation of these visits was inadequate. She noted the presence of a heel pressure area and an infected toe, and advised that Mr A's feet were not monitored or cared for adequately during his admission. RN Parmee also noted that there was a lack of follow-up for podiatric review following Mr A's infection of the toe.

200. I accept that advice. In light of Mr A's diabetes, his foot care was an important aspect of his overall health needs. I note RN D's comments that the care plans should have stated that Mr A required regular podiatric reviews. I am critical that this did not occur. I am also critical of the paucity of documentation regarding Mr A's podiatric reviews, including the reason why a review was not attended. In my view, the lack of documentation and inadequate care plans contributed to the poor monitoring and oversight of Mr A's foot care.

201. Karadean's "Diabetes Policy" stated clearly that if a resident had hyperglycaemia and a BGL above 8mmol/L, the resident was to be given insulin immediately, and medical help was to be obtained. Mr A's care plan recorded that his BGLs would be maintained between 4–12mmol/L and that his BGLs would be taken "as needed".

202. RN D told HDC that Mr A's diabetes was monitored on a regular basis, and that Mr A had yearly profile checks and blood tests every six months[60] to check his BGLs. She stated that the GP advised that blood glucose tests were indicated when Mr A was unwell.

203. Between 12 Month2 and 29 Month10, staff recorded Mr A's blood glucose readings on four occasions, and the levels recorded were between 4–12mmol/L as per his care plan.

204. On 9 Month13 and 15 Month14, Mr A's BGLs were 14.8mmol/L and 25.7mmol/L, respectively — well outside the recommended range in Mr A's care plan. The reading of 25.7mmol/L was taken by a CAP student nurse. There is no evidence that this reading was escalated to senior staff, or that the BGL was taken again. RN C stated that he has no recollection of Mr A's high blood glucose reading, and that RN D was responsible for supervision of the CAP student nurse on 15 Month14. In contrast, RN D stated that she does not recall being advised of the BGL reading on 15 Month14 and believes that another nurse was responsible for the supervision of the CAP student nurse that day.

205. I have received conflicting information about which nurse was responsible for supervising the CAP student nurse on 15 Month14, and it is highly concerning that this was unclear. In

[60] Blood tests were performed on three occasions.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

my view, the lack of oversight of the CAP student nurse contributed to the inadequate follow-up of Mr A's high blood glucose reading that day and failure to adhere to the policy.

206. Karadean acknowledged that the ongoing care of Mr A was compromised and that the regularity of staff taking his BGLs was inadequate. It also acknowledged that the diabetes management policy at the time of these events did not outline the required frequency of the BGLs.

207. RN Parmee advised that basic care of a patient with diabetes includes monitoring BGLs, particularly at times when the patient's nutrition is compromised. She noted that in Month13 and Month14, Mr A was experiencing dehydration, diarrhoea, and infection, and that these clinical observations indicated that staff needed to monitor his BGLs.

208. RN Parmee stated that the BGLs of 14.8mmol/L and 25.7mmol/L recorded in Month13 and Month14 were outside Mr A's normal range, and needed to be followed up. She noted that the finding of 25.7mmol/L was not reported, and that further testing of Mr A's BGL was not undertaken. She stated: "This high reading is indicative that Mr A was experiencing significant stress related to his diarrhoea and dehydration." RN Parmee considers that overall this represents a significant departure from the standards of expected care.

209. I agree. I am highly critical that Mr A's diabetes was poorly managed in Month13 and Month14. Of note, in Month14 Mr A experienced dehydration, diarrhoea, and infection, and multiple staff were aware that Mr A's nutrition was compromised. Despite this, staff did not increase the monitoring of Mr A's diabetes. On two occasions, high BGLs were obtained, but staff did not escalate this to a GP or repeat the readings, and departed from the Diabetes Policy. I consider that this shows a lack of critical thinking by multiple staff at Karadean, and poor adherence to the Diabetes Policy. I note that the Diabetes Policy did not guide staff on the frequency of taking blood glucose readings, and in my view this contributed to the poor monitoring of Mr A's diabetes. I also note that Karadean is reviewing this policy, which is appropriate.

Pain management

210. The "Pain Management Policy" provides that a short-term care plan or long-term care plan (resident lifestyle plan) is commenced and evaluated at least every three months. The policy notes that "the causative factors of pain are investigated by the RN and GP as required" and that "regular liaising with the GP occurs to ensure effective pain control is achieved".

211. On 3 Month7, a Short Term Care Plan was commenced owing to Mr A's redness of his groin and scrotum, and the plan directed staff to perform daily checks of this area. Between 3 Month7 and 3 Month8, staff reviewed Mr A's scrotum regularly. On 6 Month7, a GP prescribed Micreme for redness to Mr A's scrotum. A GP reviewed Mr A on 22 Month7, but there is no evidence that the GP was asked to review Mr A's scrotum. Between 4 Month8 and 17 Month14, staff recorded on multiple occasions[61] that Mr A's scrotum and groin were

[61] 03 Month7, 05 Month7, 06 Month7, 07 Month7, 19 Month7, 30 Month7, 03 Month8, 03 Month8, 25 Month8, 26 Month8, 27 Month8, 28 Month8, 28 Month8, 28 Month8, 29 Month8, 01 Month9, 07 Month9, 16

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

red. On 27 Month8, a pain monitoring form was commenced because Mr A had a sore scrotum, for which paracetamol was given.

212. RN Parmee stated that in cases of urinary and faecal incontinence it is critical that daily observations of the affected skin area are undertaken, and that appropriate pressure area care would have prevented or minimised the redness and pain Mr A experienced.

213. RN Parmee noted that the progress notes indicate that Mr A's red and sore scrotum was an ongoing issue. She stated that pain management requires the use of a pain assessment tool, a plan of care, and evaluation of that plan. RN Parmee advised that there is little evidence that Karadean staff developed adequate care plans or short-term care plans to manage the pain Mr A was experiencing. RN Parmee noted that a GP gave advice about Mr A's pain and redness on 6 Month7, and advised that staff should have asked the GP to review the area during the visit on 22 Month7. RN Parmee noted that between 3 Month7 and 18 Month10 there is no review of Mr A's pain relief, and advised that these issues could have been raised with the GP during the visits on 17 Month8 and 13 Month10.

214. I accept this advice. Mr A's redness and pain was recorded by multiple Karadean staff on multiple occasions. However, staff did not utilise pain assessment tools appropriately to assess Mr A's pain and develop appropriate care plans to manage his pain adequately. It is highly concerning that despite multiple reports of pain during Mr A's admission, GP advice was sought on only one occasion. It is highly likely that further GP advice was warranted to manage this issue, and I am critical that this did not occur. Mr A's redness and pain could have been minimised or prevented, and I am highly critical that staff did not adhere to Karadean's Pain Management Policy and utilise pain assessment tools to provide appropriate interventions.

Pressure area care

215. Mr A was assessed in Month4, and the Norton Pressure Area Risk Assessment indicated that he was at risk of developing pressure sores. Norton assessments for Mr A were conducted three monthly and remained unchanged, despite the deficits in Mr A's physical condition, mental condition, activity, mobility, and incontinence recorded in the clinical notes and in his care plans.

216. In Month10 and Month14, it was recorded that a pressure-relieving air mattress would be obtained, but there is no evidence that a pressure-relieving mattress was used throughout Mr A's admission. In Month14, RN C requested an air mattress from UCG, but UCG did not provide the air mattress requested for Mr A.

217. RN Parmee advised that the Norton assessments were inaccurate, and did not reflect the deficits in Mr A's health and mental condition recorded in his care plans and clinical notes. She stated that because of the changes in Mr A's health, the Norton assessments should have been undertaken more regularly. RN Parmee advised that a pressure-relieving air

---

Month9, 16 Month9, 16 Month10, 17 Month10, 18 Month10, 24 Month10, 07 Month11, 03 Month12, 10 Month12, 10 Month12, 13 Month14, 14 Month14, 15 Month14, 17 Month14.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

mattress should have been implemented when first documented in Month10, to minimise the pressure area risk and progression for Mr A.

218. I agree. I am highly critical of the inaccuracy and frequency of the Norton assessments. Accurate assessments guide staff in their care of patients and the institution of appropriate strategies. It is concerning that a pressure-relieving mattress was not obtained when this was indicated. In my view, the implementation of an air mattress at this juncture may have minimised Mr A's risk of developing further pressure areas. The reported status of Mr A's pressure injury by hospital staff the day following his transfer to the public hospital on 22 Month14 highlights the extremely poor care provided by multiple Karadean staff in this respect. Mr A was reviewed on 22 Month14, and his sacral wound was described as "huge" and in need of specialist wound care or surgical debridement.

Wound management

219. Mr A's sacral pressure wound was identified on 13 Month14. The following day, the wound was reviewed by a registered nurse, and a soft tissue care plan, a short-term care plan, a wound care chart, and a pressure injury assessment plan were commenced. Generally, the sacral wound was evaluated on a daily basis,[62] and the plans were updated by various staff. However, multiple staff at Karadean did not describe Mr A's sacral wound accurately in the wound care charts and progress notes, and conflicting descriptions of the wound were recorded. For example:

- On 14 Month14, the sacral wound was evaluated as black and red with 50% necrosis, but this was not recorded in the progress notes until the following day. Karadean stated that at this stage the wound was unstageable (full thickness tissue loss, base of pressure injury is covered by slough, and depth cannot be determined).
- On 15 Month14, the progress notes document the sacral wound as stage 2 (partial thickness tissue loss, presenting as a shallow, open wound with red-pink wound bed without slough).
- On 14, 15, 16, and 17 Month14 the Soft Tissue Care Plan was reviewed and the sacral wound was evaluated as black with 40% to 50% necrotic tissue.
- On 16, 17, 18, and 20 Month14, the sacral wound was evaluated as stage 2 and described as "superficial" on the wound treatment charts.

220. On 14 Month14, a pressure injury on Mr A's right ankle was noted. The same day, a photograph of Mr A's sacral wound was taken by a nurse and discussed with RN C. However, the photograph was not retained in Mr A's clinical records. Karadean said that its staff deleted the photograph because of concerns about "the legality of keeping a photograph of the wound" taken on a mobile phone. RN C stated that he believed a copy of the photograph had been printed and put in Mr A's clinical notes.

[62] 13 Month14, 14 Month14, 15 Month14, 16 Month14, 17 Month14, 18 Month14, 20 Month14, and 21 Month14.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

221. GP Dr E saw Mr A on 15 and 18 Month14 regarding his norovirus symptoms and his medication. There is no evidence that staff informed Dr E about Mr A's pressure wounds on his ankle and sacrum.

222. Karadean acknowledged the failure to meet the accepted standard of care for complex wound management, and that the documentation was a "gross departure from clear precise documentation".

223. RN Parmee advised that when the sacral wound was discovered on 13 Month14 and was unstageable, advice from a wound care specialist should have been sought within one week. She noted that staff deleted a photograph of the sacral wound without ensuring that the photograph was added to the wound documentation for Mr A. RN Parmee also advised that there was a lack of consistency and documentation in the progress notes, short-term care plans, and wound treatment charts. She said that there is a very significant difference between a stage 2 pressure injury and an unstageable pressure injury. RN Parmee stated:

> "It appears that the sacral wound was poorly managed both in terms of assessment documentation and monitoring. It is noted that the GP was not kept updated with the progress of the wound (in the list of GP visits summarised in the Ultimate Health Care investigation there is no mention of any discussion with the GP about the sacral pressure area) and most importantly there was an unnecessary failure to provide a pressure relieving air mattress. It would also have been appropriate to refer the wound to a Wound Care Specialist given the lack of healing evident in the photography provided by the public hospital staff.
>
> …
>
> At the very least this leads to poor communication between nursing staff and with the GP and therefore the risk of inappropriate treatment of the wound. Institutional wound care and documentation policies were clearly not being adhered to which amounts to poor care."

224. RN Parmee considers that there are two highly significant departures:

1. There was a lack of consistency in assessment and documentation in the wound care records, poor communication between nursing staff and between the nurses and GP, and wound care and documentation policies were not followed.

2. There was a need for medical intervention from 13 Month14 — the day on which the wound was first discovered — but this was not obtained.

225. I accept this advice. I am very concerned that when the sacral wound was discovered, staff did not report this to a GP and a wound care specialist, despite the wound being described as "unstageable". Further, multiple staff at Karadean did not describe Mr A's sacral wound accurately in the wound care charts and progress notes, and conflicting descriptions of the wound were recorded. In my view, the discrepancies in the wound care documentation

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

contributed to the poor monitoring and the communication between staff about the management of Mr A's wounds.

226. Despite multiple staff having reviewed the sacral wound and noting that it was not healing, staff did not report this to a GP or a wound care specialist. I am highly critical that this did not occur in accordance with Karadean's policy. In my view, the inaccurate wound care documentation contributed to the poor communication with the GP. The failure to report the wound to the GP on two visits in Month14 was unacceptable, and points towards an environment where nursing staff showed a lack of action, lack of critical thinking, poor adherence to policies, poor documentation, and insufficient attention to Mr A's wound care management.

Consultations with GP

227. Between Month5 and Month13, Mr A was reviewed by a GP every three months, and he had several consultations relating to changes in his health. As stated, Mr A developed ongoing health issues, including faecal incontinence, ankle and sacral pressure areas, and pain and redness of his scrotal area. On 6 Month7, GP advice was sought in respect of Mr A's scrotal pain and redness, but there is no evidence of further GP advice, despite Mr A's ongoing pain. Between Month13 and Month14, two high BGL readings were taken but staff did not escalate this to a GP. On 15 Month14, a GP reviewed Mr A owing to faecal incontinence caused by norovirus, but there is no evidence that the frequent faecal incontinence was reported to the GP. There is also no evidence in the clinical notes that Karadean staff requested GP advice on any of Mr A's pressure wounds.

228. Karadean told HDC that owing to the frequency of the GP reviews of Mr A, it considers that he had sufficient GP input into his care during his time at Karadean.

229. RN Parmee advised that the GP consultations met the Ministry of Health three-monthly review requirements when a patient is stable, and that there were instances where nursing staff appropriately escalated care to a GP for review outside of those requirements. RN Parmee noted that GP advice was sought about Mr A's redness and pain on 6 Month7. She also noted that Mr A was reviewed by a GP in Month7, Month8, and Month10, but there is no evidence that staff asked the GP to review Mr A's redness and pain. RN Parmee advised that Karadean staff would have been expected to consult with a GP for advice in relation to the management of Mr A's faecal incontinence, his ankle and sacral pressure areas, and the pain and redness of his scrotal area. RN Parmee stated:

> "While responsibility for continence, pressure area and skin care lies primarily with nurses, it is their responsibility to report difficulties providing a satisfactory level of care to the GP for the GP's information and advice."

230. I agree. I note that at times Karadean staff consulted with a GP appropriately in relation to changes in Mr A's health. However, Mr A had ongoing issues including continence, pressure areas, and redness and pain in his scrotal area, and it is evident that the nursing intervention around these issues was inadequate. I am critical that staff failed to seek advice from a GP

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

in the management of these issues, and Mr A's high blood glucose levels, when this was warranted. Mr A was reviewed by a GP regularly, and in Month14 he was seen on two occasions, but his non-healing pressure wounds were not reported to the GP by Karadean staff. In Month14, Mr A's health was compromised by an infection, and it is unlikely that he was able to advocate for himself. Therefore, he relied on nursing staff to report changes in his health to a GP, and I am highly critical that this did not occur.

Documentation

231. The "Clinical Records Documentation Policy" states that "entries must be factual, accurate, legible and complete", and that "[t]he Clinical Record is a legal document" and "must provide clear evidence of care planning, decisions made, care delivered, information shared, problems identified and actions taken to rectify them".

232. As stated, the wound care documentation was inaccurate and inadequate, and Karadean acknowledged that it was a "gross departure" from clear precise documentation.

233. On 21 Month14, RN J completed a transfer referral report to accompany Mr A to the public hospital. The report noted Mr A's primary diagnoses of hypertension, hypothyroidism, ischaemic heart disease, stroke, Type 2 diabetes mellitus, and vascular dementia, and that he was incontinent of the bowel and bladder. However, the report contained no documentation of Mr A's facial swelling, sacral wound, scrotal redness and pain, or ankle pressure injury.

234. RN Parmee noted that the section for "pertinent history" in the transfer referral report contained no record of Mr A's facial swelling, sacral wound, scrotal redness and pain, or ankle pressure. She advised that "[e]ach of these factors was highly relevant to [Mr A's] health status and nursing care on transfer to the public hospital", and she considers that the inadequate and inaccurate documentation represents a significant departure from accepted practice.

235. I agree. Documentation is a key function of registered nurses. As stated above, there was a lack of clear and accurate documentation of Mr A's health status by multiple staff, in particular regarding his wound care documentation, and staff failed to adhere to Karadean's policy. In my view, this was highly significant and contributed to the failure of staff to recognise Mr A's actual condition, and communicate this adequately to a GP and the hospital. While RN D and RN C, as the Clinical Services Managers, have some responsibility for this, I consider that overall it was Ultimate Care Group Limited's responsibility to ensure that the documentation met legal requirements and accepted standards.

Staffing skill mix

236. RN D told HDC that during her time as the Clinical Services Manager she was concerned about the skill mix of the registered nurses, and that the nurses were junior and/or inexperienced in aged care.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

237. RN C was in his first role as a Clinical Services Manager. He said that he was dissatisfied with the level of training and support he received in his first few months, and that it was unsatisfactory to support his orientation. RN C stated that the nursing staff skill mix caused resourcing issues. He said that he was required to provide high levels of supervision of staff, and had insufficient time to attend to his responsibilities as the Clinical Services Manager. He told HDC that he "raised this often with management and there were ongoing discussions to address the problem with no real changes being made".

238. Karadean told HDC that in Month12 staff at the facility included a Clinical Services Manager, a senior registered nurse, one competent nurse, three advanced beginner nurses, and two novice nurses. Karadean stated:

> "It was clear that the skill mix on site at the time of the events was considerably lacking in competent registered nurses with there being over 50% of the registered nurses requiring support in their roles as registered nurses and only two registered nurses who could provide that support."

239. Karadean acknowledged that on 15 Month14, a CAP student nurse failed to escalate Mr A's high BGL reading, and attributed this to a lack of appropriate supervision.

240. I am critical of the staffing mix at Karadean during the time of these events. I note Karadean's comments that the skill mix at the time was considerably lacking. I am concerned at the paucity of registered nurses available to provide oversight to its junior staff, and the lack of leadership over staff. I am troubled by the adequacy of the supervision of a CAP student nurse in Month14. In my view, this may have contributed to some of the oversights in Mr A's care, and Ultimate Care Group Limited must bear responsibility for this.

Policies

241. RN Parmee was provided with Karadean's revised policies that are relevant to this report. She noted that Karadean's updated policy on photographing wounds requires that photographs be taken using a camera owned by the facility. RN Parmee also noted that the revised Diabetes Policy requires that when residents who have Type 2 diabetes and are on metformin become acutely unwell, their BGLs must be taken.

242. RN Parmee advised:

> "The updated policies are excellent resources and cover all the areas alluded to in this report. However the implementation of these policies requires a well-resourced and supported environment to enable staff to provide high quality well documented care."

243. I agree. It is pleasing to note that the necessary changes have been made to the relevant policies to guide staff adequately in their care of residents.

Conclusions

244. The Ultimate Care Group Limited was responsible for ensuring that Mr A received care that was of an appropriate standard and complied with the Code of Health and Disability Services

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Consumers' Rights (the Code). I consider that the following deficiencies are apparent in the care Mr A received from Karadean:

- The continence reviews and care plans were inadequate and did not reflect Mr A's continence needs or guide staff in that care. Multiple staff recorded that Mr A had frequent episodes of incontinence and, despite this, there was no escalation to a GP.
- The care plans did not record how often Mr A required podiatric reviews. The frequency of Mr A's podiatric reviews was inadequate, and the documentation about the reviews undertaken was also inadequate.
- Between Month13 and Month14, two high BGLs were recorded, but staff did not escalate this to a GP or repeat the readings, and departed from the Diabetes Policy.
- In Month14, Mr A was experiencing acute illness caused by norovirus, but staff did not monitor his BGLs regularly.
- Staff did not utilise pain assessment tools appropriately to assess Mr A's pain and develop appropriate care plans to manage his pain adequately. Despite multiple reports of pain during his admission, GP advice was sought on only one occasion.
- The Norton assessments undertaken were inaccurate and did not reflect the changes in Mr A's health recorded in the clinical notes. A pressure-relieving air mattress was indicated in Month10, but there is no evidence that Mr A was provided with one during his residency.
- The descriptions of Mr A's wound care, made by various staff, were inaccurate and inconsistent, the monitoring of the wounds was inadequate, and neither GP nor specialist advice was sought in a timely manner. The management of Mr A's pressure injuries by multiple Karadean staff was extremely poor.
- There was a lack of clear and accurate documentation of Mr A's health status by multiple staff, in particular regarding his wound care documentation and in the transfer referral report to the hospital.
- Mr A's faecal incontinence, ankle and sacral pressure areas, and pain and redness of his scrotal area were not well managed, and staff should have sought GP advice on these issues.
- There was a paucity of registered nurses available to provide oversight to junior staff, and a lack of leadership over staff.

245. Overall, I consider that the care provided to Mr A by Karadean was inadequate. Accordingly, I find that The Ultimate Care Group Limited did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.[63]

---

[63] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: RN D — adverse comment

Introduction

246. As the Clinical Services Manager for Karadean between Month2 and Month10, RN D was responsible for providing a high level of clinical leadership to clinical (nursing) and care staff. RN D was also responsible for monitoring the provision of care to residents, and providing oversight of all resident clinical records to ensure that they met organisational and legislative requirements. Following her resignation in Month10, RN D remained at Karadean in the role of a senior nurse.

Management of pressure wounds

247. In Month7 and Month10, a nurse completed Mr A's Norton assessments and identified that his risk of developing pressure areas remained unchanged. However, these assessments did not reflect the information in Mr A's care plan and progress notes, which state that he had deficits in relation to physical and mental condition, activity, mobility, and incontinence. RN D told HDC that she relied on the nurses to report their assessments and care of their primary residents.

248. On 28 Month10, it was recorded that a pressure-relieving air mattress should be obtained to minimise the risk of developing pressure areas. However, a pressure-relieving mattress was not obtained for Mr A.

249. On 15 and 18 Month14, RN D assisted with the GP rounds but the GP was not informed about Mr A's sacral pressure wounds. RN D stated that she did not sight Mr A's sacral wound because RN C told her that he was "sorting" Mr A and that "it was not her problem". RN D also stated that the sacral wound was described as "superficial" in the wound care documentation. RN C asserts that he told RN D to inform the GP about Mr A's sacral pressure area. I am unable to determine whether RN D was told by RN C about Mr A's sacral wound.

250. My expert advisor, RN Rachel Parmee, stated that accurate assessment and documentation is a requirement of the competencies of a registered nurse, and she would not expect the Clinical Services Manager to be responsible for the quality and accuracy of individual assessments made by registered nurses. However, as the Clinical Services Manager she was responsible for the clinical oversight of staff and documentation, and for ensuring that effective nursing care was provided. RN D's oversight and monitoring of the pressure area documentation was insufficient, and she was not alert to the lack of accuracy and consistency in the documentation. RN Parmee advised that a pressure-relieving air mattress should have been obtained when this was noted in Month10.

251. I accept RN Parmee's advice that RN D was not responsible for the accuracy of assessments by registered nurses. However, she was responsible for accurate and appropriate documentation. In light of Mr A's risk of developing pressure areas, RN D should have ensured that pressure-relieving strategies were implemented. I am critical that an air mattress was not obtained when this was first indicated as a pressure prevention strategy.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I acknowledge RN D's comments that Mr A's sacral wound was described inaccurately as "superficial", which would not have alerted her to escalate it to a GP.

Pain management

252. On 3 Month7, a Short Term Care Plan for Mr A's redness of his groin and scrotum was commenced, and directed staff to perform daily checks of the area. Between 3 Month7 and 3 Month8, staff reviewed Mr A's scrotum regularly. On 6 Month7, a GP prescribed Micreme for Mr A's scrotum. A GP reviewed Mr A on 22 Month7, but there is no evidence that the GP was asked to review Mr A's scrotum. Between 4 Month8 and 24 Month10, staff recorded on multiple occasions that Mr A's scrotum and groin were red.[64] On 27 Month8, a pain monitoring form was commenced because Mr A had a sore scrotum, for which paracetamol was given.

253. RN D stated that analgesia was offered to Mr A, and that usually this was effective to manage his pain and redness. She acknowledged that at times Mr A refused pain relief, and that more could have been done when he reported pain.

254. RN Parmee observed that the clinical notes indicate that Mr A's red and sore scrotum was an ongoing issue. RN Parmee noted that a GP gave advice about Mr A's pain and redness on 6 Month7, and advised that the GP should have been asked to review the area during the visit on 22 Month7. RN Parmee noted that between 3 Month7 and 18 Month10 there is no review of Mr A's pain relief, and these issues should have been raised with the GP during the visits on 17 Month8 and 13 Month10.

255. I consider that aspects of Mr A's pain management were poor. RN D had oversight of the care planning and was alert to the extensive documentation of this issue and lack of improvement. I acknowledge RN D's comments that more could have been done. I also note that the Pain Management Policy provides that a registered nurse and a GP investigate the causative factors of pain, and that a GP be consulted to achieve effective pain control. In my view, RN D should have provided clinical leadership by ensuring that GP advice was sought and appropriate interventions were initiated to address Mr A's pain. I am critical that this did not occur.

Continence and diarrhoea

256. RN D told HDC that in Month10 a review of Mr A's toileting regimen reduced the incidence of incontinence, and that she provided education to caregivers about reporting any non-compliance with toileting. RN D acknowledged that loperamide could have been used more effectively to manage Mr A's incontinence.

257. RN Parmee advised that there was extensive documentation of Mr A's incontinence, but the review of interventions was inaccurate, and medical consultation should have been sought.

[64] 25 Month8, 26 Month8, 27 Month8, 28 Month8, 28 Month8, 28 Month8, 29 Month8, 01 Month9, 07 Month9, 16 Month9, 16 Month9, 16 Month10, 17 Month10, 18 Month10, 24 Month10.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

She noted that there was little evidence that GP advice was sought to review Mr A's medication in light of his frequent faecal incontinence.

258. I agree. RN D was aware of Mr A's ongoing issue with incontinence, despite the education provided to staff and a review of Mr A's toileting regimen. In my view, RN D should have provided clinical leadership and instigated appropriate interventions, including seeking GP advice to manage the issue and ensuring effective continence products were to hand. I am critical that this did not occur.

Diabetes and podiatry

259. RN D told HDC that Mr A's diabetes was monitored on a regular basis, and that Mr A had yearly profile checks and haemoglobin tests every six months[65] to check his BGLs. She stated that the GP advised that blood glucose tests were indicated when Mr A was unwell. RN D stated that Mr A's BGLs were taken regularly. Between 12 Month2 and 29 Month10, staff recorded Mr A's BGLs on four occasions, and the levels were between 4–12mmol/L as per his care plan.

260. On 31 Month2 and 9 Month5, a podiatrist reviewed Mr A, and no concerns were identified. On 24 Month6, a nurse specialist at the medical centre reviewed Mr A's infected right toe and recommended a podiatrist review, but this was not arranged. Mr A was not seen again by a podiatrist until 22 Month8. An appointment with the podiatrist was scheduled for 23 Month11, but Mr A did not attend, and no reason was recorded.

261. RN D told HDC that Mr A was seen regularly by a podiatrist in accordance with his care plans. However, she acknowledged that two years prior to these events and on 28 Month10, Mr A's care plan should have stated the frequency of podiatry visits, in light of his diabetes. RN D also acknowledged the delay in arranging a podiatric review following the advice on 24 Month6. She said that the delay was caused by a public holiday, and staff informed the GP that Mr A's toe was improving.

262. RN Parmee advised that she accepts RN D's statement that with yearly diabetic checks and six-monthly HbA1c monitoring, BGLs are necessary only when other clinical observations indicate this.

263. RN Parmee stated that "the expected standard is that patients with Type 2 diabetes be reviewed regularly" rather than as necessary by a podiatrist. She advised that "this review should include care of toenails and review for peripheral neuropathy[66] which is a common complication of diabetes". RN Parmee noted the frequency of reviews by a podiatrist and the documentation of the visits, and advised that these were inadequate.

264. Podiatric care was a critical aspect of the management of Mr A's Type 2 diabetes. RN D should have provided clinical leadership and oversight over the documentation related to Mr A's podiatric care. Mr A's care plan should have stated that he required regular podiatric

[65] Haemoglobin tests were performed on three occasions.
[66] A disorder caused by damage to the peripheral nervous system.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

reviews, and I am critical that this did not occur. The frequency of reviews by a podiatrist and the documentation of the visits that did occur were inadequate. Overall I am critical of the lack of attention to Mr A's diabetes needs, and in particular his podiatry care, and that this placed his well-being at risk.

Conclusions

265. I acknowledge the difficult circumstances RN D was working in and that this may have hindered her ability to meet the expectations of a Clinical Services Manager. While I accept that RN D is not solely responsible for the care provided to Mr A, she was responsible for the clinical oversight of staff and for ensuring that effective nursing care was provided to Mr A during her time as Clinical Services Manager. I note that RN D has acknowledged that aspects of Mr A's care were poor, including pain management, continence care, and podiatric care. I am critical that during her time as Clinical Services Manager, nursing staff failed to provide sufficient monitoring and oversight of the documentation, and effective nursing care in relation to pressure areas, pain management, continence care, and podiatry care.

Opinion: RN C — adverse comment

Introduction

266. RN C was employed by Karadean as the Clinical Services Manager between Month11 and Month14, and was responsible for providing a high level of clinical leadership to clinical (nursing) and care staff. RN C was also responsible for monitoring the provision of care to residents, and providing oversight of all resident clinical records to ensure that they met organisational and legislative requirements.

Continence

267. Between Month11 and Month14, Karadean staff regularly recorded on multiple occasions that Mr A was incontinent of urine and faeces. On 2 Month14, RN C reviewed Mr A's continence assessment and recorded that the outcome was unchanged from the assessment in Month10, despite changes in Mr A's overall health. On 15 Month14, Mr A was reviewed by a GP owing to multiple incidents of vomiting and diarrhoea caused by a norovirus infection. RN C accepts that he should have conducted a continence review in Month14 following the norovirus outbreak, but submitted that inadequate staffing levels during the norovirus outbreak compromised his ability to meet his responsibilities.

268. RN Parmee advised that the continence review on 2 Month14 was inaccurate, and indicated that there was no review of the appropriateness of the toileting regimen or incontinence products. RN Parmee advised that the management of Mr A's incontinence was poor, and that the episodes of incontinence contributed to the status of Mr A's skin integrity.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

269. I agree. I note the impact of the norovirus outbreak on staffing levels and RN C's ability to meet his responsibilities as the Clinical Services Manager, including that he worked extra shifts to address a staffing shortfall. I also note that RN C accepts that a continence review should have been conducted in Month14. However, I am critical of RN C's failure to conduct an appropriate continence review in Month14, and the poor management of Mr A's continence. RN C should have provided clinical leadership and ensured that appropriate interventions were implemented in light of Mr A's frequent episodes of incontinence.

Wound care management and documentation

270. On 14 Month14, RN G took a photograph of Mr A's sacral pressure wound and discussed it with RN C. RN C stated that he assumed that the photograph was printed and included with Mr A's documentation. He said that his usual practice was to take a photograph of a wound and include a copy in the pressure area treatment plan. On this occasion, RN C stated that he told RN G to delete the photograph because it was taken on her personal device. Karadean told HDC that RN G and RN C stated that the photograph was deleted because of concerns about the "legality of keeping a photo of the wound".

271. I note that no photograph was included with Mr A's clinical documentation, and that the next day RN C reviewed and updated Mr A's wound documentation. In my view, this was a missed opportunity to monitor the progress of Mr A's wounds.

272. RN C discovered Mr A's ankle pressure area on 14 Month14. On 15 Month14 he recorded his plan of care for the ankle pressure area in the clinical notes and in the existing short-term care plan for the sacral wound. He did not commence a separate care plan for the ankle pressure area to guide staff. RN C noted that as the redness on the right heel was blanchable, it would not have met the criteria for a stage one pressure injury. However, he acknowledged that a separate short-term care plan for the ankle pressure injury would have been preferable.

273. On 15 Month14, RN C reviewed Mr A's sacral pressure injury and evaluated the sacral wound as stage 2.[67] He also reviewed Mr A's Pressure Injury Assessment and Management Plan and Short Term Care Plan. RN C then recorded his plan of care in the Short Term care plan and progress notes. On the same day, RN C gave instructions to staff about the management of Mr A's pressure areas.

274. Between 16 and 20 Month14, there are discrepancies in the wound care documentation. Mr A's sacral wound was described as necrotic and unstageable, but continued to be classified as a stage 2 wound in the wound care documentation.

275. On 15 and 18 Month14, a GP reviewed Mr A but was not informed about Mr A's sacral or ankle pressure areas. RN C stated that on 15 and 18 Month14 he gave instructions to RN D, who facilitated the GP rounds, to inform the GP about Mr A's pressure areas. RN C told HDC that he was entitled to rely on the registered nurses to ensure that they were familiar with a patient's clinical notes when accompanying a GP on rounds. RN C further stated that he

[67] See paragraph 119.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

considers that there was ample information available to RN D in the progress notes, handover sheets, short-term care plan, and pressure injury management plan when she accompanied the GP on rounds.

276. In contrast, RN D stated that she was not informed about Mr A's pressure areas on 15 or 18 Month14, that the wound was recorded as "superficial", and that the pressure areas were not recorded on the GP review forms. However, the GP review forms were not provided to HDC, and I am unable to determine whether the pressure areas were noted on the form.

277. Karadean stated that RN C was required to check on critically unwell residents personally and work through the plans of care with the registered nurses, and put in place required monitoring, and arrange input from doctors. RN C stated that as the Clinical Services Manager he ought to have been in a position to review unwell patients to ensure that concerns had been reviewed appropriately by a GP. However, he said that because of the nursing skill mix he was unable to attend to all his Clinical Services Manager duties, and that this situation was exacerbated by the norovirus outbreak. He also stated that subsequently he resigned from his role because he no longer felt that the role was professionally safe.

278. RN Parmee said that there is a lack of consistency in assessment and documentation of Mr A's pressure areas, and that there is a significant difference between a stage 2 wound and an unstageable wound. RN Parmee stated that wound specialist involvement was indicated when Mr A's sacral pressure injury was discovered on 13 Month14.

279. While I do not consider that RN C was solely responsible for the wound care that was provided to Mr A, as the Clinical Services Manager he was responsible for the clinical oversight of staff documentation, and for ensuring that effective nursing care was provided.

280. RN C's oversight and monitoring of the wound care documentation was insufficient, and he was not alert to the lack of accuracy and consistency in the wound care documentation. I cannot determine whether Mr A's pressure areas were included in the GP review forms. However, it is disappointing that RN C did not ensure that a GP assessed the sacral wound in Month14. I am also critical that a separate care plan for the ankle pressure injury was not commenced. I acknowledge RN C's comment that it would not have met the criteria for a stage one pressure injury, but I remain of the view that a separate care plan was appropriate.

281. I am also critical that specialist advice was not sought when the sacral pressure area was first discovered. As the Clinical Services Manager, it was RN C's responsibility to ensure that these issues were addressed, so that Mr A received appropriate care.

Delayed medication

282. The "Medication Management System Policy" states that all medication errors will be recorded on an incident form, including errors relating to "wrong time, omissions".

283. RN C stated that on 12 Month13 he was informed by a nurse about an issue with Mr A's late dose of metoprolol. RN C instructed a nurse to place a request in the GP book for GP review

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

and sign-off of the verbal order of metoprolol, but did not give instructions to complete an incident form. He said that the pharmacy should have been contacted earlier to obtain a copy of the prescription for metoprolol, and that this caused the delay in administering the medication. RN C acknowledged that an incident form should have been completed in respect of the delay in administering Mr A's medication on 12 Month13.

284. RN Parmee advised that all medication administration errors should be reported in accordance with the facility's policies. She further commented that the importance of adherence to incident reporting policies "needs to be reiterated to all staff and particularly those whose positions require them to implement the policies such as the Clinical Services Manager".

285. I agree. As the Clinical Services Manager, it was RN C's responsibility to ensure that Karadean staff adhered to its policies. I am concerned that RN C gave incorrect advice to staff on the requirements for reporting a late dose of medication, and departed from Karadean's policy.

Conclusion

286. I acknowledge the difficult circumstances RN C was working in, and that this may have hindered his ability to meet the expectations of a Clinical Services Manager. These circumstances included the fact that he had been working extra shifts to address a staffing shortfall, the skill mix of nursing staff who were available to work, and the fact that there was a norovirus outbreak in Month14.

287. I also acknowledge and accept that RN C was not solely responsible for the care provided to Mr A. However, as the Clinical Services Manager, RN C was responsible for the clinical oversight of staff and for ensuring that effective nursing care was provided to Mr A.

288. Accordingly, I am critical that during his time as Clinical Services Manager, nursing staff failed to provide adequate continence care, wound care management, and documentation. As the Clinical Services Manager, RN C should have provided guidance to staff to adhere to Karadean's incident reporting policy. I am critical that this did not occur.

Recommendations

289. I recommend that The Ultimate Care Group Limited (operating as Ultimate Care Karadean Court):

a) Provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Provide evidence to HDC that all relevant staff have been trained in the following topics:

   i. Pressure area prevention
   ii. Pain management

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

iii. Oversight by the Clinical Services Manager for pressure area prevention and management
iv. Continence care
v. Management of diabetes
vi. Documentation
vii. Care of patients in response to the symptoms of norovirus
viii. Incident reporting policies
ix. Reporting changes of patient status to GPs

c) Conduct an audit of compliance with the policies developed in response to this complaint.

d) Review its staffing levels, including staffing ratios and the competency of individual staff to manage the requirements of the service safely on a day-to-day basis, and report the results of the review to HDC.

e) Review its induction and training programme for new staff, and report the results of the review to HDC.

f) Review the availability of continence products, alternating air mattresses, and other pressure injury prevention equipment, and ensure that there are sufficient supplies to meet the needs of its residents consistently.

g) Provide evidence to HDC that the above recommendations have been implemented, within three months of the date of this report.

290. I recommend that RN D:

a) Provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Provide evidence of having undertaken further training in care planning and assessment, within six months of the date of this report.

291. In accordance with the proposed recommendation in my provisional opinion, RN D has undertaken further training in clinical documentation.

292. I recommend that RN C:

a) Provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Provide evidence of having undertaken further training in assessment, communication, and clinical leadership, within six months of the date of this report.

293. In accordance with the proposed recommendation in my provisional opinion, RN C has undertaken further training in clinical documentation and wound care management.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Follow-up actions

294. The Ultimate Care Group 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.

295. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Ultimate Care Group Limited (trading as Ultimate Care Karadean Court), will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's and RN D's name in covering correspondence.

296. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Ultimate Care Group Limited (trading as Ultimate Care Karadean Court), will be sent to the district health board, HealthCERT, and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

297. The Director of Proceedings filed proceedings by consent against The Ultimate Care Group Limited in the Human Rights Review Tribunal. The Tribunal issued a declaration that Ultimate Care breached Right 4(1) of the Code by failing to provide services to Mr A with reasonable care and skill.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee on 2 October 2017:

"1) Whether the management and treatment of [Mr A's] pressure wounds — particularly a sacral pressure wound which was necrotic at the time of transfer to the public hospital — was adequate.

a. What is the standard of care/accepted practice?

Care of pressure areas is at the foundation of assessment and care of the elderly in any setting, particularly hospital based residential care. Health Quality and Safety Commission New Zealand states 'Pressure injuries (also known as pressure ulcers) are a major cause of preventable harm for patients using health care services (including hospital, aged residential care and home care'. Therefore the acceptable standard is that pressure areas should first and foremost be prevented through appropriate nursing care including positioning and in this case management of incontinence.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

I believe there has been a major departure from this standard in this case. This is evidenced by:

- Poor management of continence

It is clear from the progress notes and pressure area assessment records that urinary and faecal incontinence were contributing to the status of [Mr A's] skin integrity. Management of continence in more depth in response to Question 3.

- Poor monitoring of pressure areas.

The clinical notes include a Short Term Care plan dated 31 [Month7] related to redness on the groin and scrotum stipulating daily checks. Observations are recorded at the most weekly and discontinued on 29 [Month7].

The Norton Pressure Area Risk Assessment was carried out 3 monthly between 21 [Month4] through to 02 [Month14]. It is noted that there was no change in the scores over this time. The progress notes and Care Plan indicate discrepancies in this assessment in relation to physical condition, mental condition, activity, mobility and incontinence. There are deficits noted in each of these areas which are not recorded on the Norton Pressure Area Risk Assessment.

The last assessment took place on 02 [Month14]. As stated on the assessment chart this assessment should have taken place more regularly given the changes in [Mr A's] mobility, mental condition, and continence.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The Short Term Care Plan dated 28 [Month10] states measures planned to prevent pressure areas including an air mattress. There was no documentation of an existing pressure area at this time.

The next Short Term Care Plan is dated 14 [Month14] when a pressure area was noted on the natal cleft. The accompanying turning chart indicates 'pillow under ankle'. There is no other documentation of the ankle pressure area. The sacral wound is documented as superficial between 16 [Month14] and 20 [Month14] with only one mention of eschar and slough on 21 [Month14].

It is noted in the investigation carried out by Ultimate Care Group that a photograph of the wound taken on 14 [Month14] was deleted because of 'discussion of legality of keeping a photo of the wound'. This indicates a lack of understanding of the importance of photographs in monitoring the progress of the wound. Wound management guidelines (New Zealand Wound Care Society (2017), p14) specify that chronological photographs of wounds are an expected practice in the management of wounds. It is usual to gain consent from residents to photograph wounds as part of the admission process to a facility. The use of photographs would certainly have been useful given the perceived inaccuracy of documentation describing the wound in this case.

It is noted that a registered nurse from [the public hospital] contacted Karadean on 28 [Month14] to ask why an air mattress had not been used and that the information given by the Clinical Manager as to the requirements to obtain one was inaccurate. It is clear that this measure could, and I believe should, have been implemented when first documented (28 [Month10]) to minimise the pressure area risk and progression for [Mr A].

These findings concur with the review completed by Ultimate Care Group who noted a lack of accurate reporting of the progress of the wound which she notes was indicated to be unable to be staged when first noted.

It appears that the sacral wound was poorly managed both in terms of assessment documentation and monitoring. It is noted that the GP was not kept updated with the progress of the wound (in the list of GP visits summarised in Ultimate Health Care Investigation there is no mention of any discussion with the GP about the sacral pressure area) and most importantly there was an unnecessary failure to provide a pressure relieving air mattress. It would also have been appropriate to refer the wound to a Wound Care Specialist given the lack of healing evident in the photograph provided by [the public hospital] staff.

c. How would it be viewed by peers?

Peers in aged care would firstly view pressure areas as being preventable in this circumstance and would review the lack of accurate documentation, reporting and preventative care to be well below standard.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

To prevent a recurrence of this event there needs to be education of all staff on the principles of pressure area prevention, the importance of accurate, timely documentation and the need for assurance by Clinical Manager that appropriate measures are put in place to prevent pressure areas and regular monitoring of wound assessment, monitoring and treatment and referral (in this case to a wound care specialist). I note and commend the plan to implement the New Zealand Wound Care Society (2017) Guiding Principles for Pressure Injury Prevention and Management in New Zealand.

2) Whether the management of the pain/redness on [Mr A's] scrotum and bottom was adequate.

a. What is the standard of care/accepted practice?

In cases of incontinence (particularly both urinary and faecal, as in this case) it is of utmost importance that daily observation and care of affected skin areas is carried out. This, along with appropriate pressure area prevention, would have meant that the redness and pain could have been prevented or at least minimised. There is little evidence of management of the pain [Mr A] was experiencing, reporting of the redness to GP or a Short Term Care Plan in place.

Pain management requires use of an appropriate pain assessment tool, plan of care and evaluation of the plan. This does not appear to have been put in place.

There are numerous records of observation of the redness and pain (6 x [Month7], 08 x [Month8], 4 x [Month9], 4 x [Month10], 07 [Month11], 3 x 10 [Month12], 4 x [Month14],) but little mention of a plan to treat the redness or prevent further occurrence other than on one occasion 'keep clean and dry and apply moisturising cream' and one other mention of the use of Cavilon spray.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

As previously indicated the redness and pain could have been prevented and, although reported, there was no evidence of a plan of care to treat these problems. This seemingly poorly treated skin breakdown constitutes a highly significant departure from the expected standard of care.

c. How would it be viewed by peers?

My peers in education and aged care would, I believe, concur with this view.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

To prevent a recurrence of this event there needs to be education of all staff on the principles of skin care and pain management, the importance of accurate, timely documentation and the need for assurance by the Clinical Manager that appropriate measures are put in place to prevent skin breakdown and manage pain with regular monitoring that this is occurring.

3) Whether the management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea was adequate.

a. What is the standard of care/accepted practice?

Continence care, including diarrhoea, and hydration are expected basic requirements in the care of older adults in a hospital level care setting. These cares should be provided based on regular assessments leading to a documented care plan with regular evaluation and when there are changes in the status of the client.

Continence care includes the implementation of an appropriate, documented, toileting regime which is adhered to by all involved in the client's care, along with the use of appropriate continence products with regular evaluation of their effectiveness.

Assessment of hydration is integrally linked with continence care particularly in the presence of diarrhoea. Diarrhoea can lead to rapid loss of hydration and should be investigated and treated with medical input if necessary. While there was regular documentation of incidences of incontinence (5 x [Month2], 2 x [Month3], 3x [Month4], 29 [Month5], 2 x [Month6], 3 x [Month7], 6 x [Month8], 2 x [Month9], 2 x [Month10], 3 x [Month11], 24 [Month12], 4 x [Month13], 10 [Month14],) there was little evidence of review of interventions and evaluation of these.

A continence assessment dated 17 [Month1] indicates that [Mr A] was not faecally incontinent. Reviews documented 26 [Month7], 28 [Month10] and 02 [Month14] indicate that this original assessment was 'unchanged'. It is clear from the extensive list of episodes of faecal incontinence found in the progress notes that this assessment was inaccurate and indicates that there was no review of the appropriateness of the toileting regime or incontinence products.

Interventions on the Short Term care plan (dated 28 [Month10]) do not include a toileting programme and state 'administer laxatives or medication for loose bowel motions as per medication chart'. There is no evidence in medical consultations that these medications were reviewed in the light of frequent episodes of faecal incontinence.

This is, I consider, a highly significant departure from the standard of care given the effects of this lack of appropriate intervention on [Mr A] such as the development of reddened and painful skin, a large pressure area and dehydration.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mr A] had a diagnosis of Type 2 diabetes. Basic care of a client with Diabetes includes monitoring Blood Glucose levels, particularly at times when nutrition is compromised i.e. dehydration, decreased appetite and diarrhoea. A blood glucose reading of 25.7 mmol was recorded at the time [Mr A] was experiencing Norovirus. This reading falls well out of the normal range 4.4–8mmol. This finding was not reported and further regular testing appears not to have been undertaken. This high reading is indicative that [Mr A] was experiencing significant stress related to his diarrhoea and dehydration.

Foot care is also significant in the care of clients with Diabetes with the potential for Diabetic neuropathy. In [Mr A's] case there is evidence that his feet were not adequately monitored or cared for through the presence of a heel pressure area and infected toe.

The Care Plan (dated in year one of these events states the plan for podiatry input if necessary. One podiatry visit to [Mr A] is documented on 04 [Month13]. The expected standard would be that a patient with Diabetes is seen regularly, rather than as necessary, by a Podiatrist.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

Each of these findings indicate a highly significant departure from the standard of care.

c. How would it be viewed by peers?

I believe my peers in aged care and education would also view this as a highly significant departure from the expected level of basic care.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

To prevent a recurrence of this event there needs to be education of all staff on the principles of continence care, management of Diabetes, with accurate, timely documentation and the need for assurance by the Clinical Manager that planned care is implemented.

I note the comments by the company's investigator that protocols for Blood Glucose monitoring of clients with Type 2 Diabetes have been reviewed. This protocol should also include frequency of input by a Podiatrist.

4) Whether the management of an infection on his toe was adequate.

a. What is the standard of care/accepted practice?

As mentioned previously foot care is particularly important in the care of clients with Diabetes. This is noted in the progress notes of 24 [Month6] by an RN along with a plan to inform the GP. Following this [Mr A] was prescribed antibiotics and BD dressings with good effect. On the 22nd [Month7] when a Paronychia infection was noted on [Mr A's]

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

right big toe antibiotics and dressings were commenced with a plan for the Podiatrist to review next visit.

An appropriate Infection Data Care Plan was documented and implemented (22 [Month7]).

I consider this to be meeting the expected standard of care for such an infection and that the RN's decision for the toe not to be viewed was appropriate given that it had healed on antibiotics. I agree, however, with the investigator's findings that the GP should have been verbally updated on the progress of the wound.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be.

I do not consider there to have been a significant departure from standard care.

c. How would it be viewed by peers?

I believe my peers would agree with this judgement.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

5) Whether the management of his Rotovirus was adequate.

Note: I am assuming that the outbreak experienced at Karadean was Norovirus rather than Rotovirus, which usually affects young children.

a. What is the standard of care/accepted practice?

The Ministry of Health (2009) provides Guidelines for the Management and Outbreaks of Norovirus in Hospital and Elderly Care Institutions. From the evidence provided it appears that recommended precautions and protocols were followed.

It is accepted that a Norovirus outbreak puts considerable stress on staff and resources. In the case of the outbreak at Karadean it is noted that a number of staff were affected by the virus which meant that inadequate experienced staff were available to care for residents.

However, as noted by [Ultimate Care Group] the ongoing care of [Mr A] was compromised in terms of ensuring an adequate fluid balance was maintained and the regularity of blood glucose monitoring was inadequate.

The expected standard is that ongoing care continues and as stated above the ongoing care of hydration, continence and Diabetes management was inadequate prior to and following the outbreak of Norovirus.

There was also no record that [Mr A's] next of kin had been advised of the outbreak.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

In terms of management of the Norovirus outbreak protocols were observed and there was no departure from the standard of care.

c. How would it be viewed by peers?

My peers would concur with this view but would agree that ongoing care and communication were inadequate.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Ensure that staff are educated on the importance of not only observing appropriate infection control protocols but also to adequately assess and plan care of a client's responses to the symptoms of Norovirus. In this case this consisted of altered nutrition, dehydration and high blood glucose levels.

6) Whether a medication administration error, which appears to have resulted in [Mr A] having a heart attack, was adequately managed.

a. What is the standard of care/accepted practice?

The standard of practice around medication administration errors is that all errors are reported using the institution's incident reporting process. This would include a missed administration of medication. Along with the potential physical effects on the patient of a medication error, reporting contributes to the institution's auditing process and evaluation of medication administering processes.

As part of the incident reporting process the GP should have been notified. This did not occur at the time of the incident.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

There is a highly significant departure from the expected standard, particularly as the decision not to report the incident was apparently made by the Clinical Manager after being advised appropriately that the incident had occurred. I do not believe I am qualified to make a direct link between the missed medication and the heart attack. However the possibility that this may be linked reinforces the severity of this departure from the accepted standard.

c. How would it be viewed by peers?

My peers would agree with this assessment.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

The importance of adherence to incident reporting policies needs to be reiterated to all staff and particularly those whose positions require them to implement the policies such as the Clinical Services Manager.

7) Whether the investigation of his facial drooping, which was noted on 13 [Month14], was adequate.

I am unable to find reference to facial drooping in any documentation around the 13th [Month14]. There is a GP [entry] not dated 13th [Month10] which states as part of the investigation of swallowing difficulties and in the light of [Mr A's] history of stroke that there was no evidence of facial drooping. Assessment for facial drooping would be a standard investigation in ruling out a second stroke. As there appears to be no evidence of reported facial drooping it is not possible for me to comment further.

8) Whether the frequency of consultations with a GP was adequate.

a. What is the standard of care/accepted practice?

The Ministry of Health Service Specifications require that clients are reviewed by a GP every 3 months when in a stable condition and more regularly when there is a change in health status. The records provided show that the 3 monthly review requirement was met along with several other consultations in relation to infection R) big toe (26 [Month6], 30 [Month6], 22 [Month7]), swallowing difficulties (13 [Month10]), rash on lower leg (27 [Month11]), myocardial infarction (13 [Month13]), chest pain (22 [Month13]), Norovirus, dehydration (15 [Month14]), review of BP medications (18 [Month14]).

While there has been an appropriate number of consultations with the GP and the GP has responded appropriately when consulted outside of the 3 monthly review requirements, there have been situations when the GP has not been notified by nursing staff of events which would be expected to have GP input such as advice on management of faecal incontinence, the presence of ankle and sacral pressure areas, pain and redness of scrotal area and medication error.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

I believe the lack of consultation and/or notification to the GP of these significant events is a moderately significant departure from accepted practice. While responsibility for continence, pressure area and skin care lies primarily with nurses, it is their responsibility to report difficulties providing a satisfactory level of care to the GP for the GP's information and advice.

c. How would it be viewed by peers?

I believe my peers would agree with this assessment.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Orientation and education of nursing staff on when and how to report changes of patient status to GPs. This includes the documentation of comprehensive appropriate information. This process would ideally occur in collaboration with Facility GPs.

9) Whether the standard of clinical documentation, including the contents of referrals to the GP and to [the public hospital] was adequate.

a. What is the standard of care/accepted practice?

The accepted standard of clinical documentation requires comprehensive accurate assessments using recognised assessment tools, care plans (both long and short term) derived from the findings of assessment, and clearly documented interventions including frequency of monitoring and intervention. Referrals should include all relevant information using recognised formats (such as InterRai assessment summaries or a Transfer Referral Report such as that used by Ultimate Care).

Referrals to GPs or other external health providers should ideally follow a format such as the ISBAR framework (Identification, Situation, Background, Assessment and Recommendation) which is used within [the] District Health Board. This ensures that appropriate background and assessment data are included to ensure adequate information for the service that has been referred to.

As discussed previously the quality of wound care documentation was inaccurate and therefore inadequate. In addition the apparently non-healing wound was not referred to the GP.

The notes accompanying transfer to [the public hospital] include a list of medical diagnoses and ADL (Activities of Daily Living) information including continence. There is no mention of [Mr A's] facial swelling, sacral wound, scrotal redness and pain or ankle pressure in the section headed pertinent history. Each of these factors was highly relevant to [Mr A's] health status and nursing care on transfer to [the public hospital].

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

The inadequate and inaccurate documentation is a highly significant departure from accepted practice. The non-referral to the GP of the sacral wound is particularly significant as discussed earlier.

c. How would it be viewed by peers?

My peers would concur with this assessment.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Education of all staff on the importance of accurate documentation and use of appropriate frameworks. Staff need to be aware that any documentation can be used as evidence in legal proceedings and therefore it is a legal requirement to be accurate and include all relevant information. Of equal importance is the need for accurate and relevant documentation to ensure that standards of care are met.

10) Whether the relevant policies in place at Ultimate Care Karadean are appropriate and robust.

a. What is the standard of care/accepted practice.

Policies, by definition, need to be regularly reviewed and updated with a timeframe for this included in the policy. The Ultimate Care Group policies indicate a 3 yearly review cycle.

UCG's investigation highlighted the need to urgently review the Management of Diabetes policy in the absence of a documented frequency for undertaking Blood Glucose Level recordings. This discrepancy was identified in a review following these events.

The investigation also highlighted the need to update the company's Pressure Area and Wound Management policies.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

The policies sighted (Management of Diabetes and Weight Loss — Assessment and Management) appear to be relevant and robust. There is an undertaking to review Pressure Management and Wound Care policies. These were not available for view of the current policies. I do not consider there to be a departure from the accepted standard given the undertaking to thoroughly review these policies.

11) Any other matters in the case that I consider warrant comment.

Staffing and skill mix and poor performance of the CSM (Clinical Services Manager) are cited as contributing factors to the incidents which affected [Mr A's] care. The internal report indicates that these matters have now been addressed.

It is timely to reiterate the importance of:

- staff education and monitoring by senior staff that policies are being followed,
- the importance of accurate clinical documentation including assessments, interventions and evaluation
- the need for accurate and comprehensive communication with family and external health care providers."

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The following further expert advice was obtained from Ms Parmee on 26 September 2018:

"Thank you for the opportunity to review my advice about this case, in the light of the responses and documentation supplied by Karadean Court (Ultimate Care Group).

Initially I was asked to provide advice on the following:

1) Whether the management and treatment of [Mr A's] pressure wounds — particularly a sacral pressure wound which was necrotic at the time of transfer to [the public hospital] — was adequate.
2) Whether the management of the pain/redness on [Mr A's] scrotum and bottom was adequate.
3) Whether the management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea was adequate.
4) Whether the management of an infection on his toe was adequate.
5) Whether the management of his rotovirus (norovirus) was adequate.
6) Whether a medication administration error, which appears to have resulted in [Mr A] having a heart attack, was adequately managed.
7) Whether the investigation of his facial drooping, which was noted on 13 [Month14] was adequate.
8) Whether the frequency of consultations with a GP was adequate.
9) Whether the standard of clinical documentation, including the contents of referrals to the GP and to [the public hospital] was adequate.
10) Whether the relevant policies in place at Ultimate Care Karadean are appropriate and robust.
11) Any other matters in the case that I consider warrant comment.

I provided this advice on 2nd October 2017.

I have subsequently received the following documents for comment:

1. Response from Karadean Court
2. Policies
3. Clinical Documentation
4. Statement of [RN C]
5. Response from [RN D]

I note that Ultimate Care Group in its response to the expert advice agrees with my findings and recommendations, and acknowledges a significant departure from the expected standard of care by the then Clinical Services Manager and RNs. Ultimate Care Group states several of the staff and the CAP student involved in [Mr A's] care are no longer working at Karadean Care.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Based on the submissions of the two staff available to comment, [RN C] and [RN D], I have reviewed the relevant points in my initial report.

In the information provided for my initial report, I was not given names of the staff involved or the time that each was in the position of CSM. My comments related to CSM in my initial report are therefore not related to specific individuals rather to the requirements of the role at the time in question.

In my initial report, I found that there was no departure from expected standard of care with regard to the management of an infection on [Mr A's] toe, the management of the norovirus outbreak, the investigation of [Mr A's] facial drooping and existing policies.

In terms of the responses provided by the two RNs and [Ultimate Care Group] there are four main areas for further comment:

1) The management of [Mr A's] pressure injuries
2) The management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea
3) The management of the drug error resulting in [Mr A] missing a dose of Metoprolol
4) Revision of Policies and Procedures

1) The management of [Mr A's] pressure injuries

[RN D] alludes to an existing long term care plan and appropriate interventions around continence management and the use of Cavilon cream or spray to protect against the development of pressure areas. She also states that analgesia was offered but refused on occasion. She states that she did not see [Mr A's] pressure area and was not aware of its existence or severity hence the GP not being notified, when she was doing the GP round. She clearly describes the context of this occurring including poor written and oral communication in relation to information to be given to the GP, and change in her role which meant she was no longer directly caring for [Mr A]. I accept her assertion that she provided appropriate documentation and supervision of [Mr A's] care during her time as CSM.

[RN C] states that he wrote a detailed progress note and gave verbal instructions regarding the management of [Mr A's] pressure injury. He discusses the background to the photograph of the wound being destroyed before it was printed. He also mentions his efforts to obtain a pressure relieving mattress.

It appears that [RN C] was relying on progress notes and verbal handovers to both caregivers and his RN colleague rather than following the requirements to document in a care plan and on the form provided for GP review. This lack of documentation and follow up, together with the pressures of inadequate staffing appears to, I believe, contribute to the poor management of [Mr A's] wound.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In the light of the information provided by the RNs my initial statement, quoted below still stands.

> *It appears that the sacral wound was poorly managed both in terms of assessment documentation and monitoring. It is noted that the GP was not kept updated with the progress of the wound (in the list of GP visits summarised in Ultimate Health Care Investigation there is no mention of any discussion with the GP about the sacral pressure area) and most importantly there was an unnecessary failure to provide a pressure relieving air mattress. It would also have been appropriate to refer the wound to a Wound Care Specialist given the lack of healing evident in the photograph provided by [the public hospital] staff.*

2) The management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea

[RN D] describes in detail long term care plans and interventions related to each of these areas. [RN C] comments that it would be expected practice that [Mr A] would be on a toileting regime but does not mention clarifying that this was in place. He also states that he had no knowledge of the high BSL reading. He refers to [Mr A's] incontinence when he states that he instructed caregivers to ensure [Mr A's] sacral area was cleaned and free from faeces.

The inadequacy of the care [Mr A] received can again be attributed to poor documentation and communication between staff and failure to follow clinical guidelines as stated in my initial report: *To prevent a recurrence of this event there needs to be education of all staff on the principles of continence care, management of Diabetes, with accurate, timely documentation and the need for assurance by the Clinical Manager that planned care is implemented.*

Again this is against a background of stretched resources, inadequate staffing levels and inexperienced staff.

3) Management of the drug error.

[RN C] states that an incident form should have been completed.

This reflects my conclusion in the initial report:

> *The importance of adherence to incident reporting policies needs to be reiterated to all staff and particularly those whose positions require them to implement the policies such as the Clinical Services Manager.*

4) Revision of policies and procedures

I note that the revised policies include the need for digital photographs of wounds and the requirement that these be taken using a camera owned by the institution (rather than staff phones). I also note the point that blood glucose levels on people with Type 2 Diabetes on Metformin be taken when experiencing acute illness. This was, I believe

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the case with [Mr A]. I understand that a high reading was taken but not documented or followed up.

In conclusion I do not believe that my initial findings are any different on the basis of the information I have received in response to my initial report.

In relation to the submissions by the two RNs I believe that [RN D] attempted to maintain standards throughout this time but appeared to be hampered by poor resourcing and lack of support. [RN C] had poor documentation and communication which I believe led to the issues surrounding [Mr A's] care.

The updated policies are excellent resources and cover all the areas alluded to in this report.

However the implementation of these policies requires a well-resourced and supported environment to enable staff to provide high quality well documented care."

The following further expert advice was obtained from RN Parmee on 11 June 2019:

"Ref C17HDC00352

1. Thank you for the request that I provide further advice in relation to the complaint from the family of the late [Mr A] in relation to his care at Karadean Court (Ultimate Care).

In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Background

The HDC Office received a complaint from [Mr A's children] that concerns the care he received at Karadean Court from [Month2] until his transfer to [the public hospital] on 21 [Month14]. He was admitted to [the public hospital] with facial swelling (cellulitis), and passed away at [the public hospital] with a final diagnosis of septicaemia on 24 [Month14].

In addition to concern that [Mr A] died from septicaemia, the family are concerned about the general management of his health, including, but not limited to, aspects relating to:

- a sacral pressure wound;
- persistent pain/redness on his scrotum and bottom;
- incontinence, dehydration, diabetes and apparent diarrhoea;
- a toe infection;
- a period of rotavirus;
- a medication administration error which may have resulted in [Mr A] having a heart attack;

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- facial drooping, in the context of his previous history of stroke; and
- the frequency of consultations with a GP.

I provided an initial report dated 2/10/2017 in which I provided advice on the following questions

1) Whether the management and treatment of [Mr A's] pressure wounds — particularly a sacral pressure wound which was necrotic at the time of transfer to [the public hospital] — was adequate.
2) Whether the management of the pain/redness on [Mr A's] scrotum and bottom was adequate.
3) Whether the management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea was adequate.
4) Whether the management of an infection on his toe was adequate.
5) Whether the management of his rotovirus was adequate.
6) Whether a medication administration error, which appears to have resulted in [Mr A] having a heart attack, was adequately managed.
7) Whether the investigation of his facial drooping, which was noted on 13 [Month14] was adequate.
8) Whether the frequency of consultations with a GP was adequate.
9) Whether the standard of clinical documentation, including the contents of referrals to the GP and to [the public hospital] was adequate.
10) Whether the relevant policies in place at Ultimate Care Karadean are appropriate and robust.
11) Any other matters in the case that I consider warrant comment.

I provided further advice dated 26/09/2018 on the following questions:

1) The management of [Mr A's] pressure injuries
2) The management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea
3) The management of the drug error resulting in [Mr A] missing a dose of Metoprolol
4) Revision of Policies and Procedures

I am now asked to provide further advice on:

1) The management and treatment of [Mr A's] pressure wounds
2) The management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea
3) The medication administration error
4) The frequency of consultation with a GP
5) The standard of care provided by the clinical services managers (CSM)

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

For each of these areas I will address the specific questions for which expert advice is requested.

In preparing this report I have reviewed the documentation on file:

1) Complaint
2) Ultimate Care Group Response
3) Investigation Report — Pressure Area
4) Investigation Report — Care
5) Ultimate Care Group Response 4 April 2018 (Response to initial expert advice)
6) Statement of [RN C]
7) Statement of [RN D]
8) Progress notes 1 [Month2]–25 [Month14]
9) Further clinical reports and forms
10) Incident Forms
11) Short term care plans
12) Resident Lifestyle Plan (on admission)
13) Resident Lifestyle Plan ([Month10])
14) Long Term Care Facility Assessment Form year one
15) Long Term Care Facility Assessment Form year two
16) GP Notes (including GP Book)
17) [DHB] notes
18) Policies (in use in year one)
19) Policies (updated following these events)
20) Policies (updated following these events)

Review of Documents and Comments

1) The management and treatment of [Mr A's] pressure wounds.

a) The use of photographs for wound management

In my initial advice I referred to the New Zealand Wound Care Society guidelines (2017).

As the care in question refers to the events between [Month2] and [Month14] I would like to amend my advice to refer to the following resources listed by the New Zealand Wound Care society:

i) 2012 Pan Pacific Guideline for the Prevention and Management of Pressure Injury (Abridged Version) which states:

> 'Measurement of the wound should include length, width and depth. Tracing the wound margins provides a reliable indication of the progress of wound healing. Other techniques for measuring wound size include using a disposable ruler or photography including a calibrated measure. Computerised calculation (planimetry) of the wound area from wound tracings or digital photography could be considered if resources are available.'

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

ii) 2014 Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline which states:

> 'Consider using baseline and serial photographs to monitor pressure ulcer healing over time. Photographs should not replace bedside assessment, but may serve as a useful documentation strategy. If used, photographic techniques and equipment should be standardised to ensure accurate representation of the pressure ulcer condition that can be reliably compared over time.'

As (Ultimate Care Group) notes in its investigation a photograph of the wound taken on 14 [Month14] was deleted because of 'discussion of legality of keeping a photo of the wound'. As I stated in my second report:

> *This indicates a lack of understanding of the importance of photographs in monitoring the progress of the wound. It is usual to gain consent from residents to photograph wounds as part of the admission process to a facility.*

It also indicates that access to digital photography of wounds was available and therefore the guidelines of 2012 and 2014 are relevant.

b) Poor management of [Mr A's] pressure areas (sacrum and ankle)

I am asked to provide specific dates/examples, evidence of when the pressure areas were poorly managed.

i) Ankle pressure area

The pressure area on [Mr A's] ankle is mentioned once on 14 [Month14] — 'mild pink on R) foot noted. Applied pillows under leg to make sure foot is not in contact with bed.'

There is no documentation of a careplan or ongoing monitoring of this pressure area which is an expectation of pressure area management.

ii) Sacral pressure area

The PI (pressure injury) investigation reported by Ultimate Care Group lists dates and events related to the care of [Mr A's] sacral pressure injury and includes the following.

> *13th [Month14] — Skin breakdown and redness noted. Notified to RN but circumstances including business with Norovirus, unfamiliarity with residents and short staffing prevented RN follow up.*
>
> *14th [Month14]*
>
> *Broken area noted. Dark skin noticed at ends of the broken areas indicate that the wound was unstageable at this stage. The wound was described as being black/red with 50% necrosis.*

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

An unstageable pressure injury is defined as:

> Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
>
> (NZ Wound Care Society Grading Tool 2017)

This information was not documented in the progress notes until 15th [Month14] and the soft tissue care plan was incomplete.

> *15th [Month14]*
>
> *Redness noted. PI intact*
>
> *Dressing done*
>
> *Pressure assessment not evaluated by CSM*
>
> *Documented as Stage 2 — No review of soft tissue careplan*
>
> *Intention to order pressure relieving mattress if PI worsens*

The GP reviewed [Mr A] but the pressure injury was not mentioned or seen.

A stage 2 pressure injury is defined as:

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising

> (NZ Wound Care Society Grading Tool, 2017)

Clearly the initial description of [Mr A's] wound does not match the definition of a Stage 2 wound. Despite being described on 16th [Month14] as having black necrotic tissue, on the 17th of [Month14] as having 40% necrosis and on the 21st [Month14] as having 30% slough and 70% necrosis, the wound continued to be classified as Stage 2 on the wound treatment charts and described as superficial on 16 [Month14], 17 [Month14], 18 [Month14] and 20 [Month14].

The description of [Mr A's] sacral wound in notes from [the] Emergency Department on 22nd [Month14] states:

> 'Has a HUGE pressure sore on sacrum. Will need specialist wound care if not surgical debridement.'

Despite the GP seeing [Mr A] on the 15th and 18th [Month14] there was no mention or examination of [Mr A's] sacral wound. Specialist wound care should have been in place at this stage.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

There are 2 highly significant departures in terms of the management of [Mr A's] pressure injury.

Firstly, a lack of consistency in assessment and documentation in progress notes, the short term care plan and wound treatment charts. As I have indicated there is a very significant difference between a Stage 2 and an Unstageable pressure injury.

At the very least this leads to poor communication between nursing staff and with the GP and therefore the risk of inappropriate treatment of the wound. Institutional wound care and documentation policies were clearly not being adhered to which amounts to poor care.

Secondly, and of far greater significance, is the need for medical intervention from the day the wound was first discovered (13th [Month14]). This is supported by the comments made by staff in the Emergency Department 9 days after the wound was first documented.

It is noted that a registered nurse from [the public hospital] contacted Karadean on 28 [Month14] to ask why an air mattress had not been used and that the information given by the Clinical Manager as to the requirements to obtain one was inaccurate. It is clear that this measure could, and I believe should, have been implemented when first documented (28 [Month10]) to minimise the pressure area risk and progression for [Mr A].

c) Wound specialist involvement

I am asked to provide specific dates where specialist input should have been considered.

The current Ministry of Health requirement is that pressure injuries classified as Stage 3, 4 and unstageable be notified to HealthCERT. The notification includes the date that a wound care specialist is notified.

Although this requirement may not have been in place [at the time of events], the expected practice would still have been to contact a wound specialist. As the wound was discovered on 13th [Month14] and described as meeting the criteria of unstageable, the wound care specialist should have been contacted for advice on that date and view the wound within the week. The lack of healing evident in the photograph provided by [the public hospital] staff also indicates the necessity for much earlier wound specialist involvement.

2) The management of [Mr A's] incontinence, dehydration, diabetes and apparent diarrhoea

a) Diabetes management

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In my initial report I stated that [Mr A's] blood glucose reading of 25.7 mmol fell outside the normal range of 4.4–8 mmol. [Mr A's] care plan states that his BGL should be maintained between 4–12 mmol and be taken by staff as required.

I agree that the acceptable range for BGL for someone of [Mr A's] age with Type 2 diabetes and a range of co morbidities can be more flexible than the normal range and therefore amend my statement from:

> '[Mr A's] blood glucose reading of 25.7 mmol fell outside the normal range of 4.4–8 mmol'

To

> '[Mr A's] care plan states that his BGL should be maintained between 4–12 mmol and be taken by staff as required. The readings of (14.8 mmol on 09 [Month13] and 25.7 mmol on 15 [Month14]) fell out of this range and needed to be followed up.'

I still maintain that it is accepted practice that basic care of a client with Diabetes includes monitoring Blood Glucose levels, particularly at times when nutrition is compromised i.e. dehydration, decreased appetite and diarrhoea. I accept [RN D's] statement that with yearly diabetic checks and six monthly HbA1c monitoring, BGL recordings are only indicated when other clinical observations indicate this. Such observations would include dehydration, diarrhoea and the presence of infection, all of which were relevant to [Mr A] during [Month13] and [Month14].

My assertion is supported by the review of policies which stated that blood glucose levels be taken on people with Type 2 Diabetes on Metformin when experiencing acute illness. This was, I believe the case with [Mr A]. I understand that a high reading was taken but not documented or followed up.

b) Podiatrist reviews

A table is provided which indicates that [Mr A] was attended by a podiatrist on four occasions rather than the one I note in my report.

I have checked the progress and medical notes and have found the following:

31 [Month2] — Seen by podiatrist — toenails cut and filed (progress notes)

09 [Month4] — unable to find reference to this visit in progress notes, GP notes or further clinical reports and forms.

22 [Month8] — seen by podiatrist (progress notes)

24 [Month6] — [RN H] (nurse specialist) noted 3 days of erythema on the dorsum of the foot and diagnosed Paronychia and ingrown toenail. She prescribed Epsom soaks, antibiotics and review with podiatrist (GP notes). There is no mention in the progress notes of plan to arrange review with podiatrist and it appears this did not happen.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

While I accept that I did not note the visits of 31 [Month2 and] 22 [Month8] in my report I still maintain that the frequency of review by the podiatrist is inadequate. In addition there is inadequate documentation of visits which did occur and lack of follow up of the nurse specialist's recommendation for podiatrist review following infection of the toe and presence of an ingrown toenail.

The expected standard is that patients with Type 2 diabetes be reviewed regularly, rather than as necessary as stated in the careplan dated year one of these events. This review should include care of toenails and review for peripheral neuropathy which is a common complication of Diabetes.

3) Medication error

I am asked to provide further comment on the medication management on 12th [Month13], following [Mr A's] discharge from hospital in the form of evidence to support my advice about the medication error and with reference to relevant policies.

My initial report stated that:

> *The standard of practice around medication administration errors is that all errors are reported using the institution's incident reporting process. This would include a missed administration of medication. Along with the potential physical effects on the patient of a medication error, reporting contributes to the institution's auditing process and evaluation of medication administering processes.*
>
> *As part of the incident reporting process the GP should have been notified. This did not occur at the time of the incident.*

Evidence to support my advice includes:

1) The New Zealand Nursing Organisation's Guidelines for the Administration of Medicines state:

   If an error is made in the administration of a medicine, the RN must take every action to prevent any potential harm to the client, and report the error as soon as possible to the prescribing health professional, the line manager or employer (according to local workplace policy). The RN must document the incident and the action taken. A reportable event form must be completed. The RN and EN are accountable for their actions in the administration of medicines to the Nursing Council of New Zealand.

2) The Ministry of Health: Medicine Care guidelines for Residential Aged Care May (2011) state:

   - Record all medicine errors on an incident form.
   - Notify the senior RN immediately and/or the prescriber, and monitor the resident as advised.

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Analyse incidents and complaints via quality and risk management processes to eliminate, minimise and control future medicine management risks.

3) Medication administration policy Ultimate Care Group states:

   V. Documentation including Incident Reporting

   Record all medication errors on an incident form — refers to Medicine Care guides for Residential Aged care 2011.

I maintain my conclusion in the initial report:

> *The importance of adherence to incident reporting policies needs to be reiterated to all staff and particularly those whose positions require them to implement the policies such as the Clinical Services Manager.*

4) Whether the frequency of consultations with a GP was adequate

I have been provided with GP and Nurse Practitioner notes dated

- 26 [Month6]
- 30 [Month6]
- 22 [Month7]
- 17 [Month8]
- 13 [Month10]
- 04 [Month11]
- 27 [Month11]
- 22 [Month12]
- 13 [Month13]
- 22 [Month13]
- 15 [Month14]
- 18 [Month14]

I am asked to comment on the consultation with the GP in relation to

a) Faecal incontinence

The GP notes of 15th [Month14] note the inadequacy of [Mr A's] hydration in the light of his faecal incontinence and suggest to strongly encourage oral hydration and the possibility of subcutaneous fluid administration. I accept that there was appropriate referral to the GP in this instance.

b) Ankle and sacral pressure areas

It is noted that the GP was not kept updated with the progress of the wound (in the list of GP visits summarised in Ultimate Health Care Investigation there is no mention of any discussion with the GP about the sacral pressure area). I have discussed the implications of this lack of consultation in 1 b) above.

c) Pain and redness of scrotal area

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The GP notes provided do not include any reference to pain and redness of [Mr A's] scrotal area. The progress notes indicate that [Mr A's] red and sore scrotum was an ongoing issue. Although not listed in the GP consultation notes there is mention that the issue was discussed with the GP on the 6th of [Month7] and Micreme charted if needed. There is no indication that the GP saw the redness on that date. I would expect that during the visit on 22nd [Month7] the GP would have been asked to review the area. There was also no mention of a review of pain relief given the documentation in the progress notes between 03 [Month7] and 18 [Month10] of [Mr A] experiencing pain related to the redness of his scrotum. There were GP consultations on the 17th [Month8] and 13th [Month10] when these issues could have been brought to the GP's attention by nursing staff.

d) Medication error

I have discussed the need to notify the GP of the medication error in 3) above.

6) The standard of care provided by clinical service managers

As I stated in my further advice dated 17/09/2018:

> *'In the information provided for my initial report, I was not given names of the staff involved or the time that each was in the position of CSM. My comments related to CSM in my initial report are therefore not related to specific individuals rather to the requirements of the role at the time in question.'*

I am asked to provide further comment on my advice regarding the oversight by [RN D] and [RN C] in relation to the following issues:

a) Norton Pressure Area Risk Assessments

The Norton Pressure Area Risk Assessments of [Mr A] during the time [RN D] was the CSM do not reflect information documented in his care plan and progress notes.

The statement by [the] (lawyer for [RN D]) indicates that:

> 'as CSM she ([RN D]) relied on the RNs to report on their assessments and care of their primary residents.'

I agree with this statement and would not expect the CSM to be responsible for the quality and accuracy of individual assessments made by RNs. I would expect an RN to meet the competencies required for their registration including accurate assessment and documentation in relation to routine assessments such as the Norton Pressure Area Risk Assessment. As [the lawyer] notes [RN D] did take responsibility for ongoing in-service education of RNs which is appropriate for her role.

b) Referral to the GP

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

With reference to my earlier discussion about referral to the GP, the events which caused most concern occurred between [Month11] and [Month14] when [RN C] was CSM. Of particular concern were [Mr A's] pressure area and pain management.

[RN D] states that she did not see [Mr A's] pressure area and was not aware of its existence or severity hence the GP not being notified, when she was doing the GP round. (It is noted that at this time she was not the CSM.) She clearly describes the context of this occurring including poor written and oral communication in relation to information to be given to the GP and stating that the CSM ([RN C]) told her that 'he was sorting [Mr A] and he told me that I was not working on that side so not my problem'.

[RN D] acknowledges that she should have made more use of [Mr A's] PRN (as required) pain relief for the pain in his scrotal area. I also note that this issue first arose on the 3rd of [Month7] and was mentioned to the GP on the 6th [Month7]. I stand by my earlier comments that the scrotal pain and redness should have been at least mentioned to the GP during subsequent 3 monthly reviews which occurred during the time that [RN C] was CSM.

c) The management of [Mr A's] incontinence, dehydration, diabetes and diarrhoea.

[RN D] discusses [Mr A's] continence, diabetes, dehydration and diarrhoea issues and plans that were implemented and reviewed by her during the time she was CSM. It appears that [RN C] was relying on progress notes and verbal handovers to both caregivers and his RN colleague rather than following the requirements to ensure assessment documentation and review in care plans.

There is a distinct difference in the approach of the two CSMs.

[RN D] is able to provide evidence that despite very poor staffing levels and experience of RNs along with little apparent support from management she recognised the need for appropriate documentation and care planning.

[RN C], however, appeared not to maintain the standards that [RN D] aspired to. For example [RN C] comments that it would be expected practice that [Mr A] would be on a toileting regime but does not mention clarifying that this was in place. He refers to [Mr A's] incontinence when he states that he instructed caregivers to ensure [Mr A's] sacral area was cleaned and free from faeces. These examples indicate that he did not or was unable to take responsibility for ensuring that instructions were documented or being followed.

In his statement [RN C] writes that he had no previous management experience when he accepted the CSM role, with the assurance that he would be supported by the managers. He does not state the level of support received from one of the managers but says that a non-nursing facility manager was appointed soon after he started in the

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

role. He states that he did not have adequate staffing, guidance and support to fulfil the requirements of the CSM role.

I note Ultimate Care Group's response to the expert advice agrees with my findings and recommendations, and acknowledges a significant departure from the expected standard of care by the then Clinical Services Manager and RNs.

In conclusion I maintain that [Mr A] did not receive the expected standard of care during the period the complaint refers to.

With regard to the oversight provided by the CSMs I believe that [RN D] was hampered in her attempts to maintain the necessary standard of care due to inadequate staffing mix and experience and support from her managers. Her dedication to the facility and its residents is noted. I believe [RN C] was inexperienced and lacked support and this contributed to the significantly below expected standard of care that was provided to [Mr A] during his time as CSM.

References

Health Quality and Safety Commission, New Zealand Taupā i te whara pēhanga: Pressure injury prevention https://www.hqsc.govt.nz/our-programmes/pressure-injury-prevention/

New Zealand Nurse Organisation (2018) Guidelines for Nurses on the Administration of Medicines https://www.nzno.org.nz/

New Zealand Wound Care Society (2012) AWMA Pan Pacific Abridged Guideline https://www.nzwcs.org.nz/images/publications/2012_AWMA_Pan_Pacific_Abridged_Guideline.pdf

New Zealand Wound Care Society (2014) Pressure ulcers: Clinical Practice Guideline https://www.nzwcs.org.nz/images/PIAG/pressure-injuries-ulcers2014-pressure-ulcers-clinical-practice-guideline-Quick-Reference-

New Zealand Wound Care Society (2017) Pressure Injury Grading Tool https://www.nzwcs.org.nz/images/ppig/stop-pressure-injury-day-2017/a4-Grading-Tool-print-3.pdf

Ministry of Health (2011) Medicines: Care guidelines for Residential Care https://www.health.govt.nz/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf."

Names have been removed (except The Ultimate Care Group Ltd/trading as Ultimate Care Karadean Court) and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.