Bupa Care Services NZ Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC02219)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation...3
Opinion: Bupa Care Services NZ Limited — breach 22
Recommendations...31
Follow-up actions 32
Appendix A: Independent advice to the Commissioner 33

Executive summary

1. On 15 Month1[1] 2016, Mrs A (in her nineties) was discharged from a public hospital and admitted to hospital-level care at a rest home.

2. Mrs A had a long-term indwelling catheter (IDC) in place, and was unable to weight bear to mobilise. She required two-person assistance and a full sling hoist for all transfers. On admission to the rest home, Mrs A was assessed as being at high risk of developing pressure sores, and her perineal and sacral areas were evaluated by nursing staff regularly between Month2 and Month6.

3. During Mrs A's time at the rest home, there were a number of documented issues with her catheter, including dislodgement of the catheter, the catheter and catheter bag leaking, and urinary tract infections.

4. On 18 Month6, it was found that the skin on Mrs A's sacrum had broken down, and a GP arranged for her to be transferred to hospital for review. Sadly, in Month7, Mrs A died after a period of ill health.

5. Mrs A's son, Mr B, held an activated Enduring Power of Attorney (EPOA) for his mother's health and well-being. On multiple occasions Mr B raised concerns with rest home staff about the care provided to Mrs A, including management of Mrs A's IDC, the manner in which staff were using the hoist to transfer Mrs A, care of Mrs A's wounds, and the high temperature in Mrs A's room.

Findings

6. The Deputy Commissioner considered that the rest home had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code).

7. The Deputy Commissioner highlighted that a good relationship between staff and family is important to deliver good care in residential settings. Mr B was very involved in the care of Mrs A, and he had multiple concerns about that care. The Deputy Commissioner considered that the rest home should have been more proactive, and should have requested external support to guide rest home staff and support Mr B.

8. The Deputy Commissioner found that the following deficiencies were apparent in the care Mrs A received from the rest home:

- Following Mrs A's admission, multiple individual incidents occurred that showed a lack of knowledge and skill regarding IDC cares by its staff, including poor placement of the catheter bag, poor placement of the catheter tubing, incorrect positioning of the IDC tubing while in the hoist, and the catheter not being secured, resulting in it becoming dislodged.

[1] Relevant months are referred to as Months 1–8 to protect privacy.

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- Multiple staff did not adhere to the care summary plan and Bupa's catheterisation and catheter care policy.
- The rest home did not provide adequate further education to its staff on IDC management until Month6, despite being aware of ongoing issues with staff skill in relation to Mrs A's IDC early in her time at the rest home.
- Hoist and transfer training did not occur more promptly.
- Multiple nurses reviewed Mrs A's sacral wound, but did not make a referral to a wound care specialist in a timely manner.
- In Month5 and Month6, the temperatures recorded at the rest home did not comply with its policy, and exceeded its comfortable temperature range.

9. For these reasons, the Deputy Commissioner found that Bupa Care Services New Zealand Limited did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[2]

Recommendations

10. The Deputy Commissioner recommended that Bupa Care Services New Zealand Limited: (a) provide a written apology to Mr B; (b) provide evidence to HDC that all registered nurses and caregivers at the rest home have been trained in IDC cares and management, and safe moving and handling; (c) audit its compliance with its policy regarding temperature monitoring; (d) consider whether staff training on effective communication with family members is required; (e) use this report as a basis for its staff training; and (f) use the learnings and insights gained from Mrs A's experience, and disseminate this opinion more widely among all the care homes owned and operated by Bupa New Zealand.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided at the rest home to his mother, the late Mrs A. The following issue was identified for investigation:

- *Whether Bupa Care Services NZ Limited provided Mrs A with an appropriate standard of care between Month1 and Month7.*

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

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

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13. The parties directly involved in the investigation were:

Mr B	Consumer's son/complainant
Bupa Care Services NZ Limited	Provider

14. Further information was received from RN C, Clinical Manager/registered nurse (RN).

Also mentioned in this report:

RN D	Care home manager
Dr E	General practitioner
RN F	Registered nurse
NP	Nurse practitioner
Dr H	General practitioner
Dr I	Geriatrician

15. Independent expert advice was obtained from RN Jan Grant, and is included as Appendix A.

Information gathered during investigation

Complaint

16. Mrs A's son, Mr B, complained to HDC about the standard of care provided to Mrs A by the rest home between Month1 and Month7.

17. I have endeavoured to report my opinion with relative brevity, in relation to the extensive information provided by all parties involved. Having considered all of the information provided, the focus of this report is on what I consider to be the primary issues regarding the standard of care provided to Mrs A between Month1 and Month7, guided by the expert advice of RN Jan Grant. Some other matters raised in the complaint and in the course of the investigation have been addressed separately in correspondence with the parties.

Mrs A

18. Mrs A (in her nineties at the time of these events) was admitted to a public hospital on 4 Month1 from another facility where she had required hospital-level care. On 15 Month1, Mrs A was discharged from the public hospital and admitted to hospital-level care at a rest home. Mrs A was a resident at the rest home until her transfer to the public hospital on 18 Month6. Sadly, in Month7, Mrs A died after a period of ill health.

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19. Mrs A's medical history included bronchiectasis,[3] left middle cerebral artery (MCA) stroke-residual right hemiplegia[4] and dysphasia,[5] left superficial femoral artery (SFA) stenosis and ulcers (for which she underwent angioplasty[6] in 2014), osteoarthritis,[7] GORD,[8] hypertension,[9] swallowing precautions, and macular degeneration.[10] Mrs A was taking prednisone[11] long term, and had an indwelling catheter (IDC). An indwelling urinary catheter is a tube inserted into the bladder, to drain urine, with the tube held within the bladder by a small balloon that is filled with sterile water.

20. Mrs A was unable to weight bear to mobilise, and required two-person assistance and a full sling hoist for all transfers. She required the assistance of one to two persons for all activities of daily living, eating, and drinking. She required two-person assistance to reposition in bed every 2–4 hours. Mrs A had expressive dysphasia,[12] but was able to attempt to verbalise her wishes and indicate her immediate needs. She also used body language to convey her needs.

21. Mr B, Mrs A's son, held an active Enduring Power of Attorney (EPOA) for personal care and welfare for Mrs A, prior to her admission to the rest home.

The rest home

22. The rest home is owned and operated by Bupa Care Services New Zealand Limited. The facility provides hospital-level, rest-home level, and dementia-level services. The rest home is one of the care facilities contracted by the district health board (DHB) to provide hospital-level and rest-home-level care to people in the region. The rest home is one of the 48 care homes operated by Bupa New Zealand around New Zealand.

Clinical Manager — RN C

23. The Clinical Manager of the rest home at the time of events was RN C. The position description states that the purpose of the role is to provide high-level clinical leadership and support to clinical and care staff, working in close partnership with the Care Home Manager (CHM).

Care Home Manager — RN D

24. The Care Home Manager of the rest home at the time of events was RN D. The position description states that the purpose of the role is to manage the care home effectively and ensure quality improvement in service delivery, education, and staff development.

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[3] A long-term lung condition.
[4] Right-sided weakness following a stroke.
[5] Impaired ability to express using speech, writing, or signs — often a result of a stroke.
[6] A procedure to improve blood flow to an ulcer.
[7] Joint disease that results from breakdown of joint cartilage and underlying bone.
[8] Gastro-oesophageal reflux disease — inflammation of the lining of the oesophagus owing to stomach acid leaking upwards (refluxing) from the stomach.
[9] Abnormally high blood pressure.
[10] An eye disease that impairs central vision.
[11] A steroid medication.
[12] Difficulty with communication and language following a stroke.

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General practitioner and nurse practitioner services

25. A General Practice is contracted to provide general practitioner (GP) and prescribing nurse practitioner (NP) services to the residents of the rest home, and is available at all times for telephone advice and/or visits to the facility.

Admission to the rest home

Admission documentation Care Plan

26. Mrs A was admitted to the rest home on 15 Month1, and her care planning was commenced. The Admission checklist recorded that staff completed assessments in relation to admission, falls risk, pressure risk, and pain.

27. On 15 Month1, a nurse recorded that Mrs A's son, Mr B, asked to speak to the GP about his mother's catheter because he wanted the IDC removed. An IDC had been inserted on 3 Month1 owing to urinary incontinence and a suspected urinary tract infection (UTI).[13]

Admission care planning regarding IDC cares and hoist transfers

28. On 15 Month1, a registered nurse developed Mrs A's care plan summary (CPS), which is a shortened version of the care plan for use by caregivers. The rest home's Care Plan Summary policy states that a CPS is to be completed by a registered nurse within seven days of admission, and made available to caregivers[14] to assist with care delivery.

29. Under the section "Continence" in the CPS, the nurse recorded that Mrs A had an IDC. The CPS directed staff to empty the catheter bag at least once per shift. In addition, staff were to ensure that when Mrs A was in bed, the catheter bag was placed in a bowl, and when she was in a chair, the catheter bag was to be strapped to her leg.

30. Under the section "Mobility/safety", it was recorded that Mrs A required a full hoist transfer with the assistance of 2–3 persons. Staff were directed to ensure that when transferring Mrs A, her left leg was supported very well. Staff were also directed to ensure that Mrs A was sitting straight in bed.

31. RN C told HDC that on admission, Mrs A brought her own commode chair, but it was assessed by rest home staff as not being suitable, and she was provided with a tilt commode chair. RN C stated that a physiotherapist was consulted to ensure that staff performed repositioning and hoisting appropriately.

IDC cares and hoist transfers

IDC cares

<u>Month1</u>

32. On 17 Month1, a nurse recorded that Mrs A had passed urine, and that the continence pad had been saturated and was changed twice. A nurse on the afternoon shift recorded that she had difficulty with catheterisation. The "evaluation of urinary catheter" record notes

[13] An infection in any part of the urinary system (kidneys, ureters, bladder, and urethra).
[14] Caregivers provide nursing support and work under the direction of a registered nurse.

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that the IDC had become dislodged and was replaced with an IDC size 16F, with 10ml sterile water used to inflate the balloon. No reason for the dislodgement was recorded in the clinical notes or the urinary catheter record.

33. Mr B told HDC that he found Mrs A's catheter bag on the floor, with the catheter dislodged and Mrs A's bedding soaked in urine.[15] He said that Mrs A's catheter bag had been placed over the end of the bed, and not attached to the side of the bed, and that this had caused the catheter to become dislodged. He spoke to staff, and raised his concerns about the incident.

34. On 18 Month1, Mrs A was reviewed by her GP, who recorded a plan to remove Mrs A's IDC as soon as possible.

35. Between 18 and 31 Month1, staff recorded that the IDC was checked regularly and was draining well.

36. Mrs A was reviewed by her GP on 23 and 25 Month1, but there is no record that the IDC was discussed during either of these consultations.

37. On 31 Month1, a nurse noted that Mrs A was sleepy and was refusing medication. A dipstick test[16] showed an abnormal result, and a midstream urine specimen was sent to the laboratory to check for infection. It was recorded that at Mr B's request, the on-call doctor was contacted and an antibiotic was charted.

Month2

38. On 5 Month2, a nurse recorded that Mr B had complained that staff had placed Mrs A's catheter bag on her bed. The nurse recorded that caregivers were instructed to tie Mrs A's catheter bag to the side of her bed, lower than her body, to promote the draining of urine. The nurse also recorded that Mr B's concerns would be handed over to the staff on the incoming shift.

39. Mrs A was reviewed by her GP on 1 Month2, and no concerns about the IDC were recorded.

40. On 16 Month2, Mrs A was referred to the on-call GP following concerns that Mrs A's urine was concentrated and the smell was offensive. The GP charted antibiotics for a UTI, and PRN[17] medication for pain relief. A short-term care plan was commenced for the UTI.

41. On 19 Month2, a nurse recorded that Mrs A's catheter bag was leaking, and it was replaced with a new bag. The Care Home Manager's Report[18] also recorded that Mrs A's catheter bag had been leaking and was changed that day.

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[15] Mr B indicated that this occurred on 16 Month1; however, the clinical record indicates that it occurred on 17 Month1.

[16] A diagnostic tool used to check for abnormalities in a patient's urine.

[17] As required.

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42. At 4pm on 22 Month2, a nurse recorded that the catheter had been leaking, and that after repositioning it was draining well.

43. On 24 Month2, a nurse recorded that Mr B had expressed concerns about Mrs A's positioning on the commode when she was being toileted. Mr B complained that Mrs A was sitting on her catheter, and it was not strapped to her leg. He was also concerned that there were no footplates on the commode to support Mrs A's legs and feet. The nurse recorded that further discussion with staff was required in relation to commode placement and support while Mrs A was being toileted, and catheter placement while Mrs A was positioned on her bed or in a chair.

44. On 25 Month2, Mrs A was reviewed by GP Dr E. Dr E recorded: "[D]iscussion with son … we are leaving catheter for a while longer to encourage healing of the pressure sore."

45. On 25 Month2, a nurse recorded that a caregiver had advised that Mrs A's continence pad had been saturated with urine while the IDC was in place. The nurse reviewed Mrs A and noted no bladder distention,[19] and flushed the catheter and replaced the liquid in the balloon. The nurse documented a plan to "monitor urine leakage incidence as there may be a need to insert a new IDC".

46. On 26 Month2, Mr B attended a meeting with RN C and RN F to discuss Mrs A's plan of care. Following the meeting, it was recorded in the Care Home Manager's Report that staff would be vigilant about the signs and symptoms of UTI; they would encourage the use of cranberry juice; they would check that the IDC was free of kinks; and they would check that the IDC was secured with a leg strap and attached to the urine bag.

47. The following day, Mr B sent an email to RN F and RN C reiterating his concerns from the meeting in relation to medication management, management of Mrs A's bowels, the transfer technique from bed to commode or chair, and Mrs A's IDC care. Mr B stated that on two occasions he had observed that Mrs A's catheter had not been attached to her leg, and that on both occasions this had led to a complete or partial dislocation of the IDC. Mr B said that this caused Mrs A significant discomfort and pain. He asked that rest home staff review the leg straps daily and replace the straps if they became ineffective. Mr B also raised concerns about the competency of rest home staff to recognise the signs of a UTI and to manage Mrs A's catheter care.

48. In the same email, Mr B raised concerns about staff transferring Mrs A to the commode. Mr B complained that staff were not consistent with using the foot rests on the commode. In addition, he noted that the size of the sling used to transfer Mrs A varied. Mr B requested that the rest home consider reviewing the transfer techniques used by its staff, and asked that the rest home provide an update regarding a trial of a different type of commode.

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[18] RN C recorded in the Care Home Report daily events relating to Mrs A's health status, including her IDC cares.

[19] An enlarged bladder caused by urinary retention.

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49. Mrs A was reviewed by her GP on 27 Month2, and no concerns about the IDC were recorded.

Month3

50. On 3 Month3, Mr B sent an email to RN C and RN F and complained about an incident on 1 Month3. Mr B stated that Mrs A's catheter had been detached from her leg, and the catheter leg tie had been removed. He expressed concern that this may have caused the IDC to become dislodged. He said that this was distressing for Mrs A, and he asked the rest home to consider reviewing its staff's awareness and skills in IDC management. This is not recorded in Mrs A's clinical notes from 1 Month3.

51. Mrs A's clinical records indicate that the IDC was changed at 2pm on 1 Month3, and that a larger catheter size (18F) was used. The urinary catheter evaluation record noted that the IDC was due for change. A nurse recorded at 4pm that there had been no urine output, and gave instructions to the incoming nurse to monitor Mrs A's urine output and to recheck the patency of the catheter.[20]

52. A nurse reviewed Mrs A at 4.15pm, and noted that there was still no urine output. The IDC balloon was re-inflated and the IDC was flushed. Mrs A's urine was noted to be dark amber in colour, and thereafter the IDC was reported to be draining well.

53. On 3 Month3, Mrs A was reviewed by a Nurse Practitioner (NP). The NP noted that Mrs A's IDC had been changed on 1 Month3, and that Mr B had reported his concerns that Mrs A's urine was cloudy and the catheter was leaking, and he wanted to discuss the removal of Mrs A's catheter. The NP recorded that she advised Mr B about the previous issues with Mrs A's catheter removal, and suggested that they discuss the matter in six weeks' time.

54. On the same day, a nurse recorded that Mr B had reported that Mrs A's catheter was leaking and her bed was wet with urine. The nurse reviewed Mrs A and noted that the bed sheet was soaking wet, but that her continence pad was dry and the IDC was intact and patent. The nurse recorded that she was unable to perform a thorough assessment of the cause of the leakage.

55. On 23 Month3, Mr B complained to a nurse about the temperature of Mrs A's room, and requested that staff lower the temperature in the corridors of the wing. It was recorded that Mr B's request could not be met because of previous complaints from the residents in the wing that the temperature was too cold.

56. On the morning of 24 Month3, Mr B found Mrs A shivering and crying in a very cold room. He said that there had been a heavy frost, and Mrs A's window was open and her bed was wet with urine. Mr B stated that a thin blanket had been placed over Mrs A, but that this covered only part of her upper body. He was concerned that prior to his arrival Mrs A had not been attended to by staff for several hours. Mr B stated that he noted that the call bell had been discarded under Mrs A's bed, and she was unable to call for assistance.

[20] Ensure that the catheter was not blocked.

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57. A nurse reviewed Mrs A and recorded that her bed was wet with urine, and that the IDC may have leaked. The nurse checked the catheter and recorded that it was draining well. The nurse told RN D about Mr B's concerns, and it was recorded that RN D discussed these with Mr B.

58. On the same day, Mr B sent a text message to RN D and complained about the care provided on 23 and 24 Month3. He stated that RN D did not respond to the text messages he sent on 24 Month3 about his concerns. Mr B also told HDC that neither RN D nor RN C were present at the rest home on 24 Month3.

59. On 30 Month3, it was recorded that Mr B had requested a meeting with RN C and RN D to discuss his concerns.

60. On 1 Month4, RN D responded to Mr B's complaint made on 24 Month3. RN D told Mr B that an investigation of the concerns he had raised about the care provided on the evening of 23 and 24 Month3 had been undertaken. RN D advised Mr B that it had been found that staff had not closed the window overnight after he had opened it earlier that night when it had been hot. RN D stated that a staff member had not closed the window overnight but had placed a thin blanket over Mrs A during the early hours of the morning. It was also found that staff had changed Mrs A's catheter bag on two occasions during the night, and had found her in a wet bed in the early morning. Mrs A had been changed, but this had not been reported to a nurse. On the same morning, Mrs A was again found in a wet bed by Mr B. RN D told Mr B that the caregiver staff involved were new to the rest home, and that the nurse involved should have increased her supervision during Mrs A's personal cares, and should have given instructions about the monitoring and reporting of residents. RN D said that the learnings from this complaint were shared with all rest home staff, and that new caregiver staff attended an education session that included abuse, neglect, and restraint competencies.

<u>Month4</u>

61. On 6 Month4, RN D recorded that Mrs A's catheter had leaked and that the bed pad was wet with urine. RN D recorded that the catheter was flushed and irrigated, and the balloon was deflated and re-inserted.

62. On 22 Month4, a caregiver recorded that Mrs A's bed linen was changed twice because the IDC had leaked. On the same day, a nurse recorded that between 9.30 and 10.15am Mrs A's catheter had leaked. The nurse deflated the balloon, and the catheter was repositioned and the balloon reinserted. It was recorded that this was effective and had stopped the catheter from leaking, but at 2pm it was noted that the catheter had leaked again, and another nurse was asked to review the catheter. A nurse reviewed the catheter and adjusted it. It is recorded on the Catheter Change Record that Mrs A's catheter was changed owing to indwelling leaking. Staff reviewed Mrs A's catheter throughout the evening, and recorded that it was draining well and no leakages were noted.

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63. Mr B stated that at 7.30am on 22 Month4, he discovered that Mrs A's catheter was leaking. He said that throughout the day several nurses attended to Mrs A but he observed that the nurses did not want to replace the catheter. Mr B stated that the GP visited at around midday and diagnosed Mrs A with a suspected urinary tract infection. Mr B said that he sent two text messages to RN D but did not receive a response. Mr B stated that the room temperature "jumped a number of times and was well in excess of 30 degrees". He said that at 7.30pm he spoke to RN C on the telephone, who then gave instructions to the nurses to change Mrs A's catheter. Another nurse, who was not on duty that day, arrived and removed and replaced the catheter. Mr B said that it was not until 9.00pm that this occurred and the leaking IDC issue was resolved.

64. At 7.10am on 23 Month4, a caregiver recorded that Mrs A's catheter had leaked, and that she had informed a nurse.

65. At 10.50am on 23 Month4, Mrs A was transferred to the Emergency Department at the public hospital because of the leaking IDC. Mrs A was seen by a Urology registrar, who discussed her presentation with Mr B. The registrar suggested that Mrs A's catheter be changed to a suprapubic catheter, which is inserted through the abdominal wall into the bladder. It was recorded that Mr B declined a suprapubic catheter at that time. The registrar gave advice to change the size of catheter if leakage occurred, and arranged to review Mrs A in three months' time to discuss a suprapubic catheter. Mrs A was discharged to the rest home on the same day.

66. On 24 Month4, it was recorded that Mrs A's IDC had leaked on three occasions when staff had repositioned her, and that on each occasion the bed linen was changed.

67. On 25 Month4 it is recorded that at 8.15am Mrs A suffered a seizure lasting 15 seconds, and following this she was unresponsive to any stimuli. A nurse took Mrs A's observations and discussed the management of this event with Mr B. He requested that no further recordings be done until a GP or nurse practitioner had examined Mrs A, to minimise any further discomfort for Mrs A. At 9.50am it was recorded that Mrs A was awake and responsive to voices around her. A nurse monitored Mrs A until the nurse practitioner arrived. At 11.00am the nurse practitioner recorded that she had had an extensive conversation with Mr B about Mrs A's health condition. The nurse practitioner recorded that the plan was to administer medication in liquid form, and to keep Mrs A comfortable. Staff completed a short-term care plan.

68. On 27 Month4, Mrs A was transferred to the public hospital again, and was diagnosed with delirium secondary to a UTI. During her admission, Mrs A was reviewed at the Urology Clinic, and her silicone catheter was changed to a rubber catheter. She was discharged to the rest home on 2 Month5.

GP care in Month4

69. Between 1 and 25 Month4, Mrs A was reviewed by GP Dr E on seven occasions. Dr E recorded that on 22 and 24 Month4, she discussed Mrs A's catheter care with Mr B, including the possibility of changing Mrs A's catheter to a suprapubic catheter.

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Month5

70. On 10 Month5, a nurse recorded that Mr B had reported a graze on Mrs A's left thigh, approximately 3–4cm in length. The nurse handed over this information to the nurse on the incoming shift.

71. On the same day, Mr B noted that Mrs A's IDC bag had been suspended on the left-hand side of the bed, and the retaining leg strap had been detached from her right leg and was unsecured. Mr B told HDC that he noted a wound mark on Mrs A's left leg where the leg strap had been attached, and he queried whether the leg strap had been removed with force. Mr B said that he informed a nurse and asked whether an incident form had been completed, and was advised that this had not been done.

72. It was recorded on 12 Month5 that caregiver staff had noted a small amount of leakage on Mrs A's bed sheet and had changed the bed linen.

73. Mrs A was transferred to the public hospital on 18 Month5 because of a UTI and constipation. Mrs A's catheter was changed on 21 Month5, and she was discharged to the rest home on 23 Month5.

74. At 5pm on 24 Month5, a nurse recorded that a small amount of leakage had been noted, and that the IDC was checked again at 8.45pm. The nurse recorded that Mr B was informed of the incident, and that he gave instructions to staff to deflate the balloon only if there was a major leakage.

75. On 29 Month5, Mr B complained to the rest home that Mrs A had waited for over an hour for assistance to the toilet. Mr B also complained that a nurse had placed Mrs A's IDC strap incorrectly, and he was concerned that the IDC would become dislodged.

Month6

76. On 1 Month6, a caregiver recorded that Mrs A's catheter had leaked and that a nurse had been informed. The nurse attended Mrs A and recorded that her catheter bag had leaked and that the bag had been found on the floor by Mr B. A duty nurse reviewed Mrs A, and it was reported that after irrigation the IDC was draining well.

77. In an email dated 4 Month6, Mr B complained to RN D about the IDC care and management on 1 Month6. Mr B stated that he had found Mrs A in a bed soaked in urine, and she had appeared distressed and uncomfortable. Mr B expressed his concern that despite the involvement of multiple staff, there had been a long delay of approximately six hours before the blocking sediment from Mrs A's bladder had been flushed. He also complained that staff had not communicated with him directly, and questioned the competency of staff in IDC cares, and asked whether the rest home intended to take any action about this issue.

78. In response to Mr B's complaint relating to the care provided on 1 Month6, the rest home commenced a corrective action plan on 4 Month6. It was noted in the actions that first, Bupa would arrange education sessions in IDC management for its staff. The IDC bag

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would be attached to a steel frame to prevent it from slipping off the bed when a secondary bag was tied and clipped to the bed. The rest home also noted that a meeting with Mr B and the GP would be arranged to discuss Mrs A's IDC management and ensure that Mr B's concerns did not occur again.

79. On 5 Month6, a nurse recorded that a caregiver had reported that Mrs A's IDC anchor[21] on her right inner thigh was not attached. The nurse reviewed Mrs A, in the presence of Mr B, and noted that the anchor attached to the adhesive had detached with the IDC tube attached. The nurse removed the adhesive on Mrs A's right inner thigh and noted four small blisters under the adhesive. The nurse informed RN C, who looked at the blisters and told the nurse to anchor Mrs A's IDC with a leg strap. A short-term care plan was commenced, and the wound care plan was updated.

80. A resident review meeting was held on 12 Month6, and this was attended by Mr B, his advocate,[22] GP Dr H, and three nurses including RN D and RN C.

81. The rest home stated that in light of the recommendation from the Urology Service that Mrs A change to a suprapubic catheter (as discussed above in paragraph 65), a meeting was arranged with Mr B and Dr H to discuss the potential benefit to Mrs A's care by removing her IDC.

82. The rest home told HDC that a change to a suprapubic catheter would not have been undertaken without discussion and agreement from Mr B, and it was confident that Mr B understood this.

83. Mr B stated that the Urology Service did not recommend a change to a suprapubic catheter. He said that consultations with urologists had looked at options and weighed the merits of each option. He said that on 12 Month6 there was no mention of a suprapubic catheter.

84. The minutes of the meeting record that all rest home staff would ensure that Mrs A's IDC bag was firmly anchored at the bedside to prevent it from falling to the floor. It was also noted that Dr H would seek advice from the DHB geriatrician, Dr I, regarding the use of the IDC and whether it was recommended for long-term use. In addition, Dr H would seek advice from a urology nurse catheter specialist if the catheter remained, and would request advice on best practice to manage IDC cares.

85. Mr B stated that at this meeting, the rest home wanted his agreement to remove Mrs A's IDC, but he disagreed and said that this was contrary to the advice from Dr I. Mr B said that Bupa did not arrange a meeting with Dr H to discuss the benefits of removing the IDC. He said that Bupa was unable to provide answers to his questions, and he felt that their responses were dismissive. Mr B's advocate recorded a file note of the meeting, which states:

[21] A device to secure the catheter tube in place.
[22] From an Advocacy Service.

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"I supported [Mr B] at a meeting arranged by [rest home] management and the facility's new general practitioner. Attempts to get resolution were unsuccessful, due to the management maintaining incontinence products would be better than catheter use for managing [Mrs A's] condition. The doctor intervened to support [Mr B], saying management could make use of [the public hospital's] incontinence team to train staff in catheter use, and that the treatment prescribed by the hospital specialist should not be deviated from without referral back to him.

Bupa were unable to answer [Mr B's] questions regarding a recent incident related to catheter care and record keeping. They admitted that their record keeping was unreliable and therefore meaningless.

[Mr B's] concern about the heat in his mother's room was not resolved. With management stating this was a common problem and that air conditioning in the corridors was designed to provide cooling in the rooms."

86. The rest home told HDC that Mr B cited a verbal and text message conversation between himself and Dr I, and said that this information from Dr I had not been provided to the rest home.

87. Mrs A's care plan was updated on 12 Month6, and it was recorded that care staff would be "mindful of the IDC and its placement".

88. In relation to the management of Mrs A's IDC, Bupa told HDC:

"We have acknowledged that there were several occasions where Bupa care staff did not maintain foundational indwelling catheter cares. These involved the occasions when the drainage bag was placed on the floor while [Mrs A] was in bed and the external drainage tube was not being secured to [Mrs A's] leg."

89. In addition, Bupa stated:

"[Mr B's] concerns regarding the placement of the drainage bag and the securing of the catheter drainage tube to [Mrs A's] leg did [not] match with best practice, and Bupa has acknowledged this and implemented action plans."

Staff training in IDC cares and hoist transfers

90. The rest home told HDC that all staff employed in the role of registered nurse were Nursing Council of New Zealand (NCNZ) registered nurses with current NCNZ annual practising certificates. The rest home acknowledged that some staff who provided care to Mrs A were new to their role and to the facility. It said that within every nursing team there will be variation in skill levels, and that this is typical in the aged-care sector, which has a high staff turnover rate.

91. The rest home told HDC that it has orientation guidance documents for its registered nurses and caregiver positions. It said that all staff are familiarised with general policies

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and procedures before completing role-specific training. The rest home stated that during this orientation period, a new member of staff is supported by a peer, to ensure completion of the new staff member's knowledge and understanding of the processes and competencies required.

92. In relation to the skills of staff to manage IDC cares, the rest home said that at the time of Mrs A's admission to the rest home, two registered nurses were trained and able to provide catheter cares. The rest home said that these two nurses attended to Mrs A and supported the training of other staff to undertake catheter cares.

93. The rest home acknowledged that "a referral to the continence advisors at the public hospital or within the community would have both improved [Mrs A's] care and been of educational support for the Bupa staff," and that "it would also have been an opportunity for [Mr B] to receive information on catheter care from another source".

94. RN C told HDC that the qualified staff had skills and knowledge about catheter care, and that new staff were supported by senior staff and RN C in this area. However, RN C acknowledged: "[W]e could have done more training and seek involvement of DHBs resources for complex health care needs right at the very beginning." RN C said that with the benefit of hindsight, it would have been helpful to have had communication with the specialists and allied health staff who had been involved with providing care to Mrs A.

95. The rest home's education record for its staff states that on four occasions in 2016, training by a physiotherapist was provided to all staff in respect of "Moving and Handling". RN C said that education on moving and handling using a hoist for transfers was mandatory for its staff.

96. In response to the provisional opinion, Bupa told HDC that RN C and registered nurses provided one-to-one training on hoist management, IDC management, and other issues. Bupa said that this training is not usually documented, nor is documentation a requirement by Bupa. In addition, Bupa said that RN D recalled that continence training was implemented on 7 Month2 in response to Mrs A's admission.

Wound management and pressure areas

97. On admission to the rest home, Mrs A had an erythematous[23] area around her sacrum.[24] The care plan summary documented that Mrs A required full hoist assistance with two to three people, and two-person assistance with all cares. The initial wound assessment plan completed on admission stated that Mrs A had excoriated skin on her perineal area as a result of incontinence.

98. The care plan summary states that Mrs A was at risk of developing pressure sores, and was prone to bruising owing to long-term use of prednisone. It was also recorded that Mr B told staff that Mrs A had been prone to bruising from incorrect manual handling and

[23] A redness of the skin.
[24] Lower back.

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transfers from carers prior to admission to the rest home. The plan noted that a pressure-relieving air mattress had been provided, and that Mrs A's time in a chair was to be limited. Mrs A was for four-hourly turning, and staff were directed to use a "spoon hand" technique, and to turn Mrs A with her shoulder blades and hips. The InterRAI[25] assessment completed on 30 Month1 stated that Mrs A was at increased risk for skin breakdown owing to her immobility and hemiplegia. It also stated that Mrs A had intermittent redness in the skin folds under her breasts and abdomen, and in her groin/perineal areas, and that this was to be treated with creams charted by the GP.

99. It was recorded that three consultations with the GP were related to issues about Mrs A's skin condition. On 23 Month1, a GP reviewed Mrs A and noted that the skin on her perineum was inflamed.

100. On 9 Month2, a wound evaluation of the perineum and sacrum was commenced, and this area was evaluated on at least a weekly basis until 17 Month6. In response to the provisional opinion, Bupa stated that during this time Mrs A's perineal area was recorded as "100% epithelialising" or "superficial skin excoriation". In addition, Bupa stated that "at times [Mrs A] had a reddened sacrum but the skin consistently remained intact and responsive to the interventions".

101. On 25 Month3, a GP recorded that Mrs A's perineum was itchy and that her sacrum area was unchanged. On 15 Month4, a GP recorded that a rash under Mrs A's breast was reviewed.

102. During Mrs A's residency at the rest home, staff completed multiple wound care plans for each wound, and short-term care plans to support the wound care plans.[26] In response to the provisional opinion, Bupa told HDC:

> "From admission to Month6, [the] nursing assessment describes [Mrs A's] perineal area as '100% epithelialising'. Other recorded comments include 'superficial skin excoriation'. At times she had a reddened sacrum but the skin consistently remained intact and responsive to the interventions."

103. Bupa also told HDC that the DHB discharge summary dated 23 Month5 states that Mrs A had a reddened sacrum. It said that the nursing notes on 26 Month5 describe Mrs A's sacrum as "intact with no signs of discolouration".

104. On 14 Month6, a nurse recorded that the wound on Mrs A's buttocks was reviewed and discussed with Mr B. It was documented that no dressing was applied to the excoriated area.

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[25] Resident Assessment Instrument — a standardised tool for evaluating the needs, strengths, and preferences of residents in long-term care.

[26] Plans commenced on 12 Month4, 17 Month4, 26 Month5, 5 Month6, 7 Month6, and 14 Month6.

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105. That evening, a nurse applied an Allevyn dressing to Mrs A's buttocks. Mr B, in his submission to HDC, provided photographs taken on 15 Month6, which show that the Allevyn dressing was applied to broken skin on Mrs A's buttocks. The nurse documented that care staff had asked her to put a dressing on Mrs A's bottom because the nurse who had been caring for Mrs A was not available to apply the dressing. The nurse recorded that there had been no handover to advise that dressings should not be applied to Mrs A's buttocks.

106. The nurse stated that the dressing was not put on any red or broken areas of skin, but that on reflection she should have applied two Allevyn dressings. The nurse reiterated that she was not the nurse allocated to provide care to Mrs A that evening, and that the dressing was applied to prevent further decline of her pressure area.

107. At 9.30am on 15 Month6, a nurse recorded that a caregiver had reported that there was no dressing on Mrs A's bottom. The nurse reviewed Mrs A personally and noted that there was an Allevyn dressing on Mrs A's buttock. Mr B was present, and it was recorded that he was upset that the adhesive part of the dressing was on the red area of the buttock. The nurse removed the dressing and noted that the area was red and painful to touch. The nurse noted that there was no documentation in respect of the Allevyn dressing that had been applied, and completed an incident form. The form stated that the dressing had not been applied properly, which had resulted in further deterioration.

108. On the same day, Mr B complained to the rest home that staff had taken too long to respond and dress the wound on 14 Month6, and that Mrs A had been distressed and in pain from her bottom. He expressed concern that when a dressing was applied the following day, the adhesive on the dressing was applied to areas of broken skin. Further, he was concerned that the placement of the dressing was likely to have caused pain when staff turned Mrs A every two hours during the night.

109. On 17 Month6, Mrs A was reviewed by GP Dr H, who recorded: "[B]reak down of sacrum again, occurred [15 Month6]." Dr H consulted with Dr I, and recorded that Dr I would try to arrange for a wound care nurse to review Mrs A the following day, but that if this could not be arranged, then Mrs A was to be transferred to hospital.

110. On 18 Month6, Dr H recorded that Mrs A's pressure area had deteriorated overnight, and a specialist wound care nurse was not available immediately to review Mrs A, and that Mrs A was to be admitted to hospital.

111. The rest home commenced an investigation in response to Mr B's complaint on 15 Month6, and responded formally on 31 Month6. The rest home acknowledged that the dressing applied on 14 Month6 should have been done with proper assessment and documentation, and that there are better ways of placing a dressing on the buttocks. In addition, the rest home acknowledged shortcomings in the communication between staffing shifts.

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112. The rest home told Mr B that it had identified learnings from his complaint, and had asked its staff to attend training on wound management documentation, and to ensure that Mrs A was repositioned properly whilst on the bed, and to adhere to side-to-side turns, and also to continue to liaise with appropriate allied health professionals, GPs, or specialists if needed.

Environment at the rest home

113. The nurses at the rest home monitored the temperature of the rooms in the facility, and generally recorded this on a weekly basis from Month1 for nine months.

114. On 12 Month4, Mr B arrived at the rest home and found that Mrs A was flushed and sweaty, and she confirmed to him that she was uncomfortable. He stated that the heater above Mrs A's bed was radiating down onto Mrs A. In the following days, Mr B raised with RN D his concerns about the temperature in Mrs A's bedroom, and questioned whether this could be affecting Mrs A's skin conditions.

115. The rest home told HDC that in response to Mr B's concerns on 12 Month4, a sun-blocking blind was fitted to Mrs A's room.

116. Mr B stated that the room temperature on 22 Month4 "jumped a number of times and was well in excess of 30 degrees".

117. On 5 Month5, RN D recorded the temperatures in the rooms at the rest home. It was recorded that the corridors at the rest home were between 27 and 35.5°C, and the rooms were between 26.5 and 34.1°C.

118. On the same day, RN D completed a Bupa Hazard form, and assessed the risk rating as major and catastrophic, with actions in response required to be taken immediately and within 1–2 days.

119. The weekly temperatures recorded in the wing where Mrs A resided between 21 Month5 and 26 Month6 ranged between 24.1 and 28.7°C.

120. The rest home told HDC that the Bupa Hazard report was discussed with the Regional Operations Manager, and sent to the General Manager, the Regional Operations Manager, and the national Health and Safety Co-ordinator of Bupa, as well as the Bupa Property Manager.

121. The rest home stated that two days after the Bupa Hazard form was completed, an air-conditioning contractor attended the rest home and assessed the facility. Following this, Bupa purchased solar films, which were applied to the skylights in the hall to reduce the heat in the hallway. The rest home said that this was completed within two weeks of the Bupa Hazard form being completed. It said that Mrs A was moved to a different bedroom in the wing, away from the direct heat from the skylights.

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122. The rest home noted that Mr B provided an air-conditioning unit for Mrs A's room, but complained that the temperature of the room remained a concern. The rest home said that a further assessment of the facility was arranged, and it was recorded that the temperatures in the rooms had reduced by 2°C.

123. Between 9 and 10 Month5, in four emails, Mr B complained to RN D about the temperature of Mrs A's room and the IDC cares performed by staff.

124. On 29 Month8, Mr B complained to the rest home again, and stated that during Mrs A's residence there had been numerous occasions on which he had noted that the thermometer in her room had read 32 or 33°C. He stated that Mrs A found the room temperature "distressing", and he expressed concern that this was contributing to her poor sleep and medical conditions.

125. The rest home acknowledged that the room temperatures in some parts of the facility exceeded acceptable levels, and noted that according to NIWA,[27] 2016 was New Zealand's warmest year since their records had commenced. The rest home told HDC that after Month 6, sun-blocking blinds were fitted to all the rooms that faced towards the sun, and that air-conditioning units were installed. The rest home also told HDC that Mr B was informed of the actions taken in response to his complaints about the temperatures within Mrs A's room.

126. In response to the provisional opinion, Bupa stated that in Month5 an offer was made to move Mrs A to a cooler side of the building, but this was declined. In addition, Bupa said that Mrs A was closely monitored for comfort and hydration.

Further information — the rest home

127. Bupa stated that on multiple occasions Mr B gave instructions to staff on the management of Mrs A's cares, such as catheter care, bowel management, skin care, and wound management. Bupa said that it was unclear about Mr B's source for the instructions, but acknowledged that earlier discussions to address his concerns may have helped the ongoing communication.

128. In response to the provisional opinion, Bupa told HDC that it provided extensive training and education sessions to its staff in 2016 in relation to continence management; pressure injury prevention; moving and handling; manual handling; wound management; and abuse and neglect.

Subsequent events

129. Bupa told HDC that around mid 2017, 10 nurses at the rest home had attended sessions on catheterisation. In addition, education sessions about continence management were attended by 22 staff, including registered nurses and care staff. The rest home stated that

[27] National Institute of Water and Atmospheric Research.

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training and upskilling in respect of catheterisation and continence management would be ongoing.

130. In addition, the rest home told HDC that in Month7, it delivered training to its staff as part of its "Handling Moving" month. Also in 2017, three education sessions regarding wound management were delivered.

131. In response to this complaint, the rest home told HDC that its staff were aware to seek input and advice from nurse specialists. It said that further education was provided to its staff in relation to:

- Critical thinking;
- Direction and delegation;
- Understanding the role of a gerontology nurse specialist;
- Process, education, and mentoring for the Care Home Manager; and
- Managing challenging situations.

Independent unannounced surveillance audit

132. In 2018, an external agency[28] undertook an unannounced surveillance audit of the rest home. Of the seven areas assessed, three were partially attained and rated as a low to moderate risk. The audit found that improvements continue to be required in relation to care planning, documentation, responsiveness to call bells, and training for the wound nurse champion.

Independent audit of clinical records

133. As a result of complaints made by Mr B in relation to Mrs A's care, the DHB requested an audit of the rest home's clinical records. In 2018, an independent nurse specialist audited five random files of hospital-level-care residents at the rest home. The audit found no areas of concern, and made only one recommendation — that when a resident returns to the rest home from hospital, staff should perform a head-to-toe physical assessment.

Ministry of Health Certification

134. In 2018, the rest home's designated auditing agency undertook a full certification audit. In addition, the DHB asked HealthCERT to confirm the findings of the independent unannounced surveillance audit and independent audit of clinical records. Of the 50 standards assessed by the auditing agency, four were partially attained, and improvements were required in relation to family notification, quality data trends analysis, care planning documentation, and implementation of turning charts. Corrective actions were required within 60–90 days.

[28] Supports DHBs to develop efficient health services.

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Relevant policies/procedures

135. The rest home has written policies for catheterisation, including procedure information sheets for female catheterisation, bladder irrigation, obtaining a catheter specimen, and urinary catheter removal.

136. Bupa's policy "Catheterisation and Catheter Care"[29] states:

> "<u>Catheter care</u>
>
> …
>
> Always ensure the tubing is free of kinks, and drainage bag is kept below the level of the bladder …
>
> <u>Closed bag drainage system</u>
>
> …
>
> Bags should always be positioned below the level of the bladder and emptied appropriately and they should be hung on suitable stands to avoid contact with the floor.
>
> A leg bag is attached directly to the catheter and at night a night bag is attached to the leg bag. Each morning the larger night bag is removed and discarded and the leg bag stays in place.
>
> …
>
> <u>Potential problems</u>
>
> Signs that a catheter may be blocked.
>
> - Reduced urine output draining into bag …
>
> Staff have various options available and may try any of the following
>
> - Reposition the tubing ie check bag is below the level of the bladder, make sure that there are no kinks in tubing, make sure the resident not sitting on it, check the bag is hanging correctly. …
>
> If the catheter is leaking consider the following and take appropriate action to correct any identified
>
> - Kinking
> - Constipation
> - Bladder spasm or irritation
> - Positioning
> - Restrictive clothing

[29] Reviewed in February 2012.

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If leakage continues

- Deflate the balloon and check amount obtained with care plan to see how much had been put in — as the balloon may have perished — and re-inflate the balloon
- Try replacing with a smaller gauge catheter
- Contact GP for further review"

137. The rest home's policy regarding wounds and management[30] states:

"Accessing specialist advice

- Registered Nurses are responsible for completing referrals for specialist advice which is readily available through appropriate channels (see below)
- Referrals should occur promptly if there is little evidence of improvement in a wound, where interventions appear not to be achieving the desired healing outcome or:
    - whenever there is rapid deterioration
    - complex or non-healing wounds
    - any concern re skin malignancy
    - possible osteomyelitis
    - arterial insufficiency
    - evidence of vasculitis
    - highly exudating wounds

Some Care Homes are aligned with DHB outreach programmes where Gerontology Nurse Specialist can offer advice on wound management and Wound Nurse specialists can be accessed through DHBs. (Contact the Quality and Risk team if problems/delays in accessing specialist advice.)

Wound product advice can also be obtained via wound product supplier (eg Smith and Nephew product specialist)."

138. The rest home's policy regarding temperature monitoring — indoor air/hot and cold water supplies[31] states:

"Indoor air temperatures

- To ensure the comfort and wellbeing of our residents and staff the desired air temperatures, in a resident's living space, will be maintained at a minimum of 19°C. Non-living spaces shall be maintained at a minimum of 16°C. Most people will be

[30] Reviewed in February 2012.
[31] Implemented May 2008 and last reviewed in Month7.

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comfortable in a temperature range between 19°–24°C. To ensure that all sites comply with this requirement, they will;

- Monitor and document the air temperature in corridors, resident lounges and dining areas weekly.

…

- If the temperatures monitored fall outside the guidance temperature parameters they must be reported immediately to the Care Home/Village Manager. Where the accepted temperature range is not able to be restored, this will be reported to the Regional Property Manager for action."

Responses to provisional opinion

139. Mr B, RN C, and Bupa were provided with relevant parts of my provisional opinion. Responses have been incorporated where appropriate. Some matters have been addressed separately in correspondence with the parties. In addition, I note the following:

Mr B

140. Mr B was given an opportunity to comment on the "information gathered" section of the provisional opinion. In his response to HDC, Mr B stated that he has elected not to make any comment on the "information gathered" section of the provisional opinion. In 2019, Mr B wrote to a government organisation to express his concerns about this complaint. In his letter to the government organisation, Mr B commented on the events outlined in the "information gathered" section of my provisional opinion, and I have incorporated Mr B's comments into the report where appropriate.

RN C

141. RN C stated that all efforts were made to keep Mr B informed and up to date during Mrs A's residency at the rest home. RN C recalled that Mrs A was happy during her time at Bupa.

Opinion: Bupa Care Services NZ Limited — breach

Introduction

142. Bupa Care Services New Zealand Ltd had a duty to provide Mrs A with services with reasonable care and skill. It had responsibility for the actions of its staff, and an organisational duty to facilitate continuity of care. It also had a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

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

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IDC management

143. Mrs A was a hospital-level resident at the rest home from Month1 until Month6. On admission, Mrs A had a long-term IDC due to urinary incontinence. The initial care plan summary directed staff to empty the catheter bag at least once per shift, ensure that when Mrs A was in bed the catheter bag was placed in a bowl, and ensure that when she was in a chair the catheter bag was strapped to her leg.

144. At the time of these events, the rest home had a Catheterisation and Catheter Care Policy that directed staff to ensure that the tubing was free of kinks, and that the drainage bag was kept below the level of the bladder. If problems with the IDC occurred, the Policy directed staff to check that there were no kinks in the tubing, make sure that the resident was not sitting on the tubing, and check that the bag was hanging correctly.

145. From the time that Mrs A was admitted, caregiver staff attended to her daily personal cares and transfers from bed to chair and to a commode. Mrs A was not able to care for her IDC herself, and at all times she was dependent on staff for her needs.

146. Between Month1 and Month3, there were issues with the placement of the IDC. It was found that the IDC was positioned on Mrs A's bed, over the end of Mrs A's bed, and underneath Mrs A while she was sitting, and at times this caused the IDC to become dislodged. The nurses were informed of these incidents by Mr B or caregivers. Following two incidents, the nurse gave instructions to caregiver staff about the position of the IDC, and noted that further discussion was required in response to these issues.

147. Mr B raised concerns about the placement of the catheter in the days following Mrs A's admission, and his concern that this caused the catheter to become dislodged.

148. The catheter became dislodged on 16 Month1, shortly after admission, but there is no documentation of the reason for the dislodgement.

149. In Month2, Mr B complained to a nurse about the placement of Mrs A's IDC bag on her bed, and the nurse recorded that she gave instructions to caregiver staff regarding the appropriate placement of the IDC bag.

150. On three occasions in Month2, the IDC had not been attached to Mrs A's leg. Mr B noted that on two occasions this had led to a complete or partial dislocation of the IDC and had caused Mrs A pain and discomfort, and may have contributed to the urinary tract infections she experienced from time to time.

151. Mr B raised concerns about the level of skill and competency of staff to manage Mrs A's IDC cares, and requested that staff review Mrs A's IDC leg straps daily. He also questioned the techniques used by staff when transferring Mrs A to the commode.

152. On 26 Month2, staff were directed to make further checks to ensure that the IDC was free of kinks and secured with a leg strap. However, between Month3 and Month6, a further four incidents were reported whereby Mrs A's catheter was not attached to her leg and

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became completely or partially dislodged, and Mrs A appeared distressed and uncomfortable. On one occasion, it was noted that the anchor attached to the adhesive had also detached.

153. Information regarding Mrs A's care was recorded daily, but there is no documentation of the reason the IDC became dislodged soon after admission, and no incident form was completed when Mr B reported a wound on Mrs A's thigh when the IDC became dislodged.

154. RN Grant advised:

> "[Mrs A] had an Indwelling urethral catheter long term. She was admitted to [the rest home] with this and throughout her stay there were problems relating to the catheter and catheter cares. At times the catheter became displaced and there were issues around positioning of the catheter tubing and bag when in bed and on the chair. The notes show that there were times when the IDC functioned well. At other times, leakage of urine from around the catheter was a problem. The long-term care plan was more informative. Medical staff and nurse practitioners were, in my opinion, aware of the concerns and care issues with the management of [Mrs A's] IDC, although they would, in my opinion, have limited knowledge of the experience and skills of the care staff that provided the daily cares. My experience is that many long-term IDCs do present a nursing challenge. It is not uncommon for them to block, particularly if fluid intake is at times limited. When there are multiple medical problems as in [Mrs A's] case, these may add to the difficulties with catheter management. Urinary tract infections are a common side effect of long term IDC use. In my opinion, clinical notes show that when [Mrs A] became unwell, appropriate intervention occurred. The notes also show there were times when [Mr B] asked for urine to be checked and a specimen sent to the laboratory. Medical staff was kept informed. When the lab results indicated infection, treatment was commenced. Medical staff endeavoured to not use antibiotics unnecessarily as this might lead to the establishment of resistant organisms. Similarly, staff tried to limit the number of times the catheter was irrigated, as this may increase the incidence of infection. Medical staff at [the rest home] and [the public hospital] suggested a suprapubic catheter for [Mrs A] but this was declined by the family. Evidence shows that family had a number of meetings — both formal and informal — with nursing staff, medical staff and visiting nurse practitioners. Admissions to the Public Hospital were arranged when clinically indicated. Registered staff knowledge in relation to IDC cares appears to have been inconsistent, with some staff having appropriate clinical knowledge to provide cares and carry out procedures when necessary. Other staff, however, had limited knowledge. Daily personal cares were provided by health care assistants who showered, washed, dressed, assisted with meals and fluids and provided the support required over a 24hr period. Health care assistants would have positioned the IDC tubing following showers, toileting etc. and would contact the registered nurse if they had concerns.

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The progress notes are generally well documented by care staff and registered nursing staff. Most of the entries by the care staff are very thorough. However, there are omissions in relation to specific events, e.g. how the catheter became dislodged soon after admission. Evidence is available to show that they did seek advice and contacted the RNs when necessary. Events that occurred such as initially keeping the catheter bag on top of the bed, poor placement of the catheter tubing, allowing the IDC bag to hang thus causing pressure on the IDC itself, incorrect positioning of the tubing while the patient was in the hoist and not securing the day bag on the side of the bed causing the catheter to pull, in my opinion, show lack of knowledge and practice. This was identified early in the admission. There are comments and emails from [Mr B] with respect to this, and in my opinion, this was an area which should have been actioned soon after admission. Education should have been provided to care assistants in a more timely manner e.g. in [Month1/Month2]. Registered Staff, also in my opinion, should have had additional education in relation to IDC care in a more timely manner. Identifying the concerns in [Month6] appeared to be as a reaction to events rather than a proactive approach to cares and support. A quality improvement initiative could have been used to show an improvement process which would have been in keeping with the complaints policy.

Communication with the family is evident in the clinical notes. Family appeared to visit frequently and regularly. [Mr B] appeared at times to direct staff in relation to cares and support. Progress notes state that at times the registered staff and care staff felt intimidated. His request for IDC irrigation which was against the advice of medical staff obviously caused concern for staff. His complaints and concerns in relation to IDC cares were, in my opinion, justified at specific times as they related to specific events …

It is my opinion that the IDC cares, on the whole, met an acceptable standard. However, the events which [Mr B] identified to the facility and which were documented in the clinical notes, would be viewed as a mild to moderate departure from acceptable standards by my peers, simply due to the fact that a staff education programme, introduced sooner, may have prevented these events from occurring."

155. Mrs A was accepted as a resident at the rest home with a long-term IDC in place. At the time of her admission, the care plan summary and relevant policy directed caregiver staff and nurses on the positioning and placement of the IDC. Rest home staff should have been guided by the policy and care plan summary to provide IDC cares, and I am critical that at times staff did not adhere to the care plan and policy.

156. While I note RN Grant's advice that overall the IDC cares met an acceptable standard, it is apparent that the level of skill and expertise with IDC cares varied, and I am critical that this contributed to deficiencies in the IDC care provided by rest home staff.

157. A functioning IDC was essential for Mrs A's well-being and, as discussed above, on numerous occasions it did not function adequately. It is understandable that Mr B has

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concerns about the care provided to Mrs A in this regard, particularly as she developed urinary tract infections, which undoubtedly will have contributed to her state of ill health.

158. In light of the concerns that Mr B raised with the rest home, and observations of its nurses about the need for further education of its staff, I am highly critical that it was not until five months later that the rest home took steps to provide education and specialist support for its staff around IDC cares. I note that the rest home told HDC that on Mrs A's admission, only two nurses, including the Clinical Manager, were competent to manage IDC cares. I also note that the rest home acknowledged that it should have sought specialist advice from a continence advisor to provide education to its staff on the most appropriate treatment regimen for Mrs A. I agree that this would have been helpful.

Training and education

159. In 2016, Bupa provided training and education sessions to its staff in relation to continence management; pressure injury prevention; moving and handling; manual handling; wound management; and abuse and neglect.

160. RN C recorded in the Care Home Manager's Report the regular incidents regarding Mrs A's IDC cares, and it is evident that these concerns were raised with her by the nurses. RN C acknowledged that additional training and support from specialist services would have been helpful following Mrs A's admission.

161. The rest home told HDC that on admission, the facility had two nurses who were skilled in catheter care. Throughout Mrs A's residency, multiple nurses carried out procedures in relation to IDC cares, and on 1 Month6, a nurse recorded that another nurse had been asked to review Mrs A, owing to the lack of competency with catheter care.

162. Bupa told HDC that RN D recalled that she implemented continence training on 7 Month2, but this was not recorded. Bupa also said that RN C and registered nurses provided one-to-one training on hoist management and IDC management, but there was no requirement by Bupa to document this training.

163. In Month6, the rest home offered IDC education to its nurses, and agreed to seek specialist input from a geriatrician and a urology nurse catheter specialist for advice on managing IDC cares. The rest home acknowledged to HDC that earlier specialist advice in respect of catheter care would have improved Mrs A's care and education for its staff.

164. RN Grant advised that incidents in relation to the IDC management were identified early following Mrs A's admission, and that these showed a "lack of knowledge and practice". RN Grant noted that Mr B raised the issues with the rest home. RN Grant stated:

> "Education should have been provided to care assistants in a more timely manner eg in [Month1/Month2]. Registered staff, also in my opinion, should have had additional education in relation to IDC care in a more timely manner. Identifying the concerns in [Month6] appeared to be as a reaction to events rather than a proactive approach to

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cares and support. A quality improvement initiative could have been used to show an improvement process which would have been in keeping with the complaints policy."

165. RN Grant advised me that it was the responsibility of RN C and RN D to initiate extra education for its staff in relation to IDC management when concerns were raised by Mr B shortly after Mrs A's admission.

166. I note that in Bupa's further response it advised that RN C, RN D, and other registered nurses initiated education to staff around IDC cares, but that this was not documented. It is not clear to whom the training was provided, or the extent or content of the training. I also note that Bupa and RN C acknowledge that earlier specialist advice about catheter care and training would have been helpful for its staff. While I do not dispute that informal training and education around IDC cares occurred, I consider that this was insufficient in light of the evident lack of staff knowledge and practice around IDC cares, highlighted by the ongoing issues with Mrs A's IDC. I remain critical of RN C's and RN D's response to providing training to staff around IDC cares. While I note that formal training was implemented in Month6, I agree with RN Grant that further training and education around IDC cares was indicated much earlier in Mrs A's admission.

167. Regarding education about moving and handling, RN C said that this was mandatory for staff. RN D was responsible for responding to Mr B's complaints, and in doing so was aware of the issues he raised and the responsiveness of the rest home. Bupa told HDC that one-to-one training on hoist management was provided by RN C and registered nurses, but that this was not documented.

168. With regard to hoist transfers, RN Grant considers that education should have been initiated for care staff in Month1 in response to the concerns raised by Mr B about toileting.

169. While I note that education about moving and handling was provided to Bupa staff, I also note the concerns raised by Mr B to Bupa in respect of the use of the hoist transfer. I agree with RN Grant that further education around hoist use and transfers was indicated much earlier in Mrs A's care, and I am critical that this did not occur.

Wound management and pressure areas

170. On admission to the rest home, Mrs A had an erythematous area around her sacrum. She was assessed early on in her admission, and it was noted in the care plan summary that she had a high risk of developing pressure sores and was immobile. Staff were directed to use handling techniques and a sling hoist for all transfers. In addition, it was noted in the InterRAI assessment that Mrs A had redness in skin folds under her breasts and abdomen and in her perineal area. The care plan directed staff to turn and reposition Mrs A every 2–4 hours. Mrs A was provided with an air mattress, and the amount of time spent sitting in a chair was limited, owing to her risk of developing pressure sores.

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171. At the time of these events, the rest home's wound management policy stated that nurses were responsible for making referrals for specialist advice, and noted the situations when this should be considered, including "when interventions appear not to be achieving the desired healing outcome".

172. In Month2, wound evaluation of the perineum and sacrum was commenced, and the areas were evaluated at least weekly until 30 Month6. Bupa told HDC that from Mrs A's admission until Month6, staff noted that while Mrs A had a reddened sacrum, her skin was intact and responsive to the interventions. During Mrs A's residency, GPs reviewed her skin condition, and in Month3 it was noted that the sacral area remained unchanged.

173. On 15 Month6, it was recorded that a nurse was asked to dress Mrs A's sacrum, and an adhesive dressing was placed on her buttock. Mr B complained that when the dressing was removed, it was found that the adhesive had been placed on the red part of the buttock, and this was painful for Mrs A. There is no documentation regarding placement of the dressing, but an incident form was completed by another nurse. The rest home commenced an investigation into the incident, and acknowledged that the application of the dressing on the buttock was done without proper assessment and documentation, and that staff communication between the shifts could have been better.

174. On 18 Month6, it was noted that the skin on Mrs A's sacrum had broken down, and a GP arranged a transfer to hospital for review.

175. RN Grant advised me that staff were aware of the risk of skin breakdown and pressure area development, and that when new events occurred, staff acted appropriately and sought medical advice. RN Grant noted that the incident in Month6 was "unfortunate", and may have exacerbated the skin breakdown, but considers that staff carried out appropriate interventions following this.

176. RN Grant advised that Mrs A's admission to hospital in Month6 was "appropriate and timely". However, she noted that a referral to a wound care specialist earlier would have been appropriate to support staff in their care planning. Overall, RN Grant considered the wound care and pressure area care to have been a mild departure from accepted standards.

177. I accept RN Grant's advice. I note that generally the wound care and pressure area care was acceptable. However, I also note that after commencing the documentation to monitor and evaluate Mrs A's sacral wound, it was a further four months until a referral was made to a wound care specialist for advice. I note that the relevant policy guided nurses to consult a wound care specialist if wound care interventions were not achieving the desired outcome. I am concerned that multiple nurses reviewed Mrs A's sacral wound, but did not make a referral to a wound care specialist in a timely manner.

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Environment at the rest home

178. Between Month4 and Month8, Mr B made complaints to the rest home about the high temperature of Mrs A's room, and that Mrs A was uncomfortable and distressed in this environment.

179. In response to Mr B's complaint in Month4, the rest home increased its weekly recording of room temperatures.

180. Room temperatures recorded on 5 Month5 were between 26.6 and 34.1°C, and between 21 Month5 and 26 Month6, room temperatures were between 24.1 and 28.7°C. I note that RN D completed Bupa's Hazard Form approximately two weeks after Mr B complained about the temperature of Mrs A's room. The risk assessment identified that action was required immediately or within two days.

181. Bupa management arranged an assessment of the facility two days after the Hazard Form was completed, and accepted the recommendation for fitted solar films to skylights in the corridor. Further steps were also taken, including moving Mrs A to another room, fitting sun-blocking blinds after Month 6, and fitting air-conditioning units.

182. Mr B provided an air-conditioning unit for Mrs A's room, but complained that the temperature of the room remained a concern, despite the actions taken by Bupa.

183. I note that RN D raised with Bupa management her concerns about the temperature of the rooms. I also note that when Bupa management was made aware of these concerns, corrective action was taken within two days, in accordance with its relevant policy. In addition, I note that in response to the provisional opinion, Bupa told HDC that it made an offer to move Mrs A to another room in the facility, and said that Mrs A was closely monitored for comfort and hydration.

184. RN Grant advised:

> "Older people are at high risk of developing heat-related illness because their ability to respond to summer heat can become less efficient with advancing years associated medical conditions. It also must be noted that some immobile patients are unable to remove themselves from excessive heat and/or remove bedding which exacerbates their discomfort … The facility undertook a risk assessment of this issue and identified it as a high risk to patients. Preventative measures were also taken and these were appropriate. UV blocking film was also added to the windows and this was noted to have made a significant improvement."

185. I agree with RN Grant's comments. I remain concerned that while Bupa management took actions in Month4 when the concerns were first brought to its attention, the temperature of Mrs A's room remained uncomfortable for her in Month5. I note Bupa's policy that a comfortable temperature range is between 19–24°C, but that in Month5 and Month6 the temperatures recorded at the rest home exceeded this range. In this regard, I am

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concerned that Bupa did not comply with its policy. In my view, the high temperatures recorded were concerning for the health and well-being of Mrs A and other residents.

Mr B's concerns

186. A good relationship between staff and family is important to deliver good care to residents in residential aged care settings. Mr B made extensive complaints to the rest home about the care provided to Mrs A, shortly after her admission and particularly in Month5. In Month6, five months after Mrs A's admission, the rest home sought specialist support from the DHB.

187. RN Grant advised: "[T]here was an acceptable level of communication in a timely manner between Mr B and [s]taff. I am also of the opinion that my peers would view this as consistent with acceptable standards." I note that the rest home has acknowledged that earlier discussion with Mr B about his concerns may have helped its ongoing communication with Mr B.

188. RN Grant advised:

> "[O]nce the relationship with [Mr B] became difficult for the staff, management should then have initiated specialist advice from [a] [g]eriatrician. … Support from outside specialists would have supported the organisation and [Mr B] at this time."

189. I agree. It is evident that Mr B was very involved in the care of Mrs A, and that he had multiple concerns about that care. In light of Mr B's extensive complaints, Bupa should have been more proactive, and should have requested external support to guide staff and support Mr B. I am critical that this did not occur. Mrs A's care may well have benefited from earlier multidisciplinary meetings with her family and the various health professionals involved in her care.

Conclusion

190. In my view, the rest home had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code. I consider that the following deficiencies are apparent in the care Mrs A received from the rest home:

- Following Mrs A's admission, multiple individual incidents occurred that showed a lack of knowledge and skill regarding IDC cares by its staff, including poor placement of the catheter bag, poor placement of the catheter tubing, incorrect positioning of the IDC tubing while in the hoist, and the catheter not being secured, resulting in it becoming dislodged.

- Multiple staff did not adhere to the care summary plan and Bupa's catheterisation and catheter care policy.

- The rest home did not provide adequate further education to its staff on IDC management until Month6, despite being aware of ongoing issues with staff skill in relation to Mrs A's IDC early in her time at the rest home.

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- Hoist and transfer training did not occur more promptly.
- Multiple nurses reviewed Mrs A's sacral wound, but did not make a referral to a wound care specialist in a timely manner.
- In Month5 and Month6, the temperatures recorded at the rest home did not comply with its policy, and exceeded its comfortable temperature range.

191. For these reasons, I consider that the care provided to Mrs A by the rest home was not adequate. Accordingly, I find that Bupa Care Services New Zealand Limited did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

192. I recommend that Bupa Care Services New Zealand Limited:

a) Provide a written apology to Mr B for the failures identified in this report. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Mr B.

b) Provide to HDC, within three months of the date of this report, evidence that all registered nurses and caregivers at the rest home have been trained in IDC cares and management.

c) Provide to HDC, within three months of the date of this report, evidence that all registered nurses and caregivers at the rest home have been trained in safe moving and handling.

d) Audit its compliance with its policy regarding temperature monitoring — indoor air/hot and cold water supplies, and provide HDC with the outcome of the audit within six months of the date of this report.

e) Consider whether staff training on effective communication with family members is required, and report back to HDC the outcome of its consideration, within three months of the date of this report.

f) Use this report as a basis for its staff training, and provide evidence of that training to HDC.

g) Use the learnings and insights gained from Mrs A's experience, and disseminate this opinion more widely among all the care homes owned and operated by Bupa New Zealand.

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Follow-up actions

193. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services New Zealand Limited, will be sent to the Ministry of Health (HealthCERT), the DHB, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Jan Grant on 13 March 2019:

"I have been asked to provide an opinion on the care provided to [Mrs A]. I have no personal or professional conflict of interest in the case. My advice is based solely on a review of the documentation provided. I have read and agreed to the Commissioner's guidelines. I am a Registered Nurse with over 30 years of experience in Aged and Community Care. In that time I have had a variety of roles. I have been Manager and Director of Nursing of an aged care facility and in community care for 17 years. I have represented the NZNO and the Aged Care Sector on a number of national working parties. I have been involved in setting standards for Practice for Gerontology Standards. I have been a clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My immediate past role was as Clinical Advisor/Rehabilitation Coordinator in the community. I am a designated assessor for ACC. I have post graduate qualifications in nursing and a Master's degree in management, with nursing ethics and research as a focus.

<u>Background</u>
[Mrs A] (in her nineties) [was] admitted into the rest home in [Month1]. She was assessed as a hospital level patient requiring a high level of nursing care due to her limited mobility and daily care needs. She had multiple medical problems and medical staff documented her medical conditions as follows:

Osteoarthritis Swallowing symptoms — presbyoesophagus
CVA involving the left middle cerebral artery
Residual right hemiplegia and dysphasia
Peripheral vascular disease
Gastro-oesophageal reflux
Bronchiectasis
Macular degeneration
Left superficial femoral artery (SFA) stenosis and ulcers — angioplasty 2014
Hypertension
Long term prednisone use
Long term IDC for urinary incontinence

An interRAI undertaken on 30 [Month1] states that [Mrs A] had expressive dysphasia, but that she attempted to verbalise her wishes. She also used body language to convey her needs. She was able to comprehend well but could not process too much information at once. She had no hearing problems and was able to see clearly. The assessment of her activity of living function notes that she needed help with all ADLs. She required two staff to assist with a full-sling hoist when getting out of bed. [Mrs A] required full assistance with showering and dressing. She needed full assistance with meals and had to be well positioned to take oral fluids due to delayed swallowing. [Mrs A] was able to verbalise when she had pain or discomfort. Her next of kin is listed as her son, [Mr B], who had EPOA for personal care and welfare. She also had another son who lived locally. [Mrs A] was admitted to [the rest home] in [Month1] until

[Month6], at which time she was admitted to [the public hospital] where she passed away in [Month7].

Questions

The adequacy of [Mrs A's] care plan

[Mrs A's] care planning was commenced on admission on the 15 [Month1]. A number of forms demonstrate that family was present at admission. The admission checklist notes the date and areas completed. This includes risk assessments such as falls risk and pressure risk. Pain assessment and nutritional requirements were completed. A care plan summary was developed on the 16 [Month1]. An InterRAI assessment was completed on the 30 [Month1]. An initial care plan meeting checklist was completed on the 26 [Month2] and was signed by a family member (EPOA). A client-centred long-term care plan was documented on the 17 [Month2]. This identified all the supports required for ADLs. It also identified [Mrs A] as being at high risk of choking secondary to her CVA. This care plan documented her daily choice for cares and her preferred daily routine. It outlined her agreed support in relation to staff assistance. It also outlined how her medical conditions had affected her ADLs and the support she would require. This included IDC cares and use of a sling hoist for transfers. The section of the care plan relating to transfers using the hoist was thorough. Pressure area risk was noted with appropriate interventions eg an air mattress was used. A separate urinary catheter management plan was also documented, with very clear agreed support and interventions. Medical assessment was undertaken on the 16 [Month1] by [the GP]. This was a general assessment with medications and long-term classifications listed. Physiotherapy assessments and reviews were also documented. Individual assessments included falls risk assessment, skin assessment, pain assessment, cultural assessment and activities assessment. These were appropriate and timely. A mobility transfer plan was documented on the 15 [Month1] and again on the 12 [Month5]. On the 26 [Month2] and the 12 [Month6], resident reviews were undertaken. Areas of care for review were listed and notes made on the progress of [Mrs A's] cares and support. These were signed by a registered nurse. On the 7 [Month2] an email was sent to [Mr B] with the attachment of the short-term care plan. [Mr B] replied with an email seeking clarification of the term 'regularly check'. He also stated he was concerned about the proposed times around morning toileting and breakfast. He suggested that between 9am–10am would be the preferred time. Staff responded on the 8 [Month2] and advised that they had updated the short term care plan as per [Mr B's] request. Family were included in the care plan development and documentation shows that staff would involve [Mrs A's] family in changes made to care management.

Care planning is always ongoing and frequent, particularly when there are changes in the patient's condition. At these times changes in care plans are made and documentation is updated. In [Mrs A's] case, short term care plans were used to identify and manage short term issues. Overall, the assessment and care planning were appropriate. The plan was very client centred and included specific goals and interventions appropriate to [Mrs A]. Evidence demonstrates family had input and staff were very receptive to the requests of the family. The reviews were timely and relevant. Medical staff consulted regularly with [Mrs A], and [Mr B] (EPOA) was included in these consultations. Overall the documentation relating to the care plan

would, in my opinion, meet the requirement for certification and would be viewed as adequate care planning by my peers.

<u>2. The Management of [Mrs A's] indwelling catheter</u>

<u>Staff competency in indwelling catheter management</u>
To clarify and answer this question I will attempt to summarize the IDC cares by each month following admission.

<u>[Month1]</u>
Following admission an assessment was undertaken. The care summary was dated the 15 [Month1] (the day of her admission). Under the heading of 'Continence' it was noted that [Mrs A] had faecal incontinence. It was also noted that she had an IDC (indwelling urinary catheter). The entry reads: 'Empty at least once per shift. Ensure it (the catheter bag) is in a bowl when in bed and strapped to leg when in chair. 6 weekly changes.' In addition, [Mrs A] was charted cranberry capsules daily and ural sachets as required to a maximum of 4 per day. She received regular laxsol to prevent constipation. 15 [Month1] … Admission notes documented on the 15 [Month1] by an RN state: '*the son said he wants to talk to the GP tomorrow regarding the meds and catheter use as he wanted the IDC to be discontinued'.* 16 [Month1] 0700hrs '*… IDC intact and draining well 700mls output of clear urine …'* Medical notes from a visit by her GP document that the '*Urinary catheter pulled out this am. I think it should be replaced'* 18 [Month1] … Doctor's notes include '*IDC I will get it out as soon as possible'* 23 [Month1] and 25 [Month1] … Doctor visited again. IDC was not identified in medical notes. 17 [Month1] … the IDC become dislodged and was replaced as identified in the Evaluation Urinary Catheter care plan. There is no entry in the progress notes to state how this happened. The night staff on the 17 [Month1] notes that the patient had passed urine: *'has passed urine, pad fully saturated. Changed x 2.'* The notes show that an IDC size 16 was reinserted with 10mls sterile water used to inflate the balloon. Progress notes from the 17 [Month1]–31 [Month1] indicate that the IDC was patent and draining well. The fluid balance summary shows adequate input and output. 27 [Month1] … Doctor visit. Micreme charted as requested by RN. PRN for under breasts. 31 [Month1] ... an MSU was sent to the Lab at the request of [Mr B]. It was reported in the notes that [Mrs A] had been sleeping a lot and refusing medications. Prior to the urine specimen being sent staff dip-sticked her urine and identified an abnormal result. Notes state that at the son's request the on-call doctor was contacted. Augmentin was charted. A short-term care plan was commenced.

<u>[Month2]</u>
5 [Month2] … Progress notes '*had a talk with son [Mr B] as he is not happy to see the catheter bag placed on bed. Have spoken with the care staff to tie the bag on the side of the bed lower than her body to promote drainage of urine will hand over to incoming shift this concern'* 6 [Month2] … Care Manager's report '*[Mrs A] c/o pain at IDC site, regular paracetamol given. IDC secured with tape, good effect'* 10 [Month2] … Progress notes '*reported urine cloudy in drainage bag and tubing. [Mrs A] denies pain on abdomen/suprapubic area; encourage (increase) fluids as tolerated. Urine drainage bag changed to a new one to monitor urine output; draining well. Urine clear when checked @ 2200. To send urine spec on Monday. Handover given to nocte RN to*

monitor further' 11 [Month2] … Urine was reported clear and IDC draining well. 12 [Month2] … Lab spec of catheter urine showed a heavy growth mixed organisms. 16 [Month2] … progress notes 2100 hrs: '*referred [Mrs A] to on call GP re concentrated urine, offensive smelling urine, dipstick test leucos, blood + nitrates … [the on-call GP] charted antibiotics for UTI and PRN meds ??? Suprapubic pain, Encourage good fluid intake. Compliant with meds + cares charted creams applied STCP initiated. Endorsed to nocte RN'.* 19 [Month2] … Email from RN to [the on-call GP] re UTI 19 [Month2], 15.25 hrs: '*IDC patent; Urine bag changed as anal leaking. New urine bag in place. Mild haematuria noted. Handed over to the night shift RN. Still on antibiotics for UTI. Adequate food and fluid intake.'* 22 [Month2] 1600hrs … *reposition the catheter as was leaking. Catheter patent, draining* well …' 24 [Month2] 1000hrs … '*I had a discussion with [Mr B] (son) around his concerns regarding [Mrs A's] positioning on the commode when being toileted, [Mrs A] was sitting on her catheter and the catheter was not strapped to her leg. Also there were no footplates on the commode to support [Mrs A's] legs and feet. There needs to be some discussion around commode placement and support while [Mrs A] is being toileted and catheter placement while she is laying on her bed and chair*'. Signed by RN. 25 [Month2] 1110 hrs … Progress notes *'RN informed by care staff [that] [Mrs A's] pad was saturated with urine while IDC in situ. No bladder distension noted: flushed the catheter with sterile normal saline, no resistance noted. Replaced the liquid on the balloon extracted 6mls of fluid replaced with 6mls of sterile water for injection. To monitor urine leakage incident as … maybe a need to insert new IDC. Discussed with [Mr B] that perineal area is slowly improving; he wants to know when it will heal completely; told him it will take 6 weeks or more as healing process in elderly is very slow.'* 26 [Month2] … Care Manager's Report indicates that a Multidisciplinary meeting was held with [Mr B] present. Points 10 and 11 of the record made of the meeting relate to the IDC. Point 10 states that staff must be vigilant for signs and symptoms of UTI and for staff to utilize her stock of cranberry juice in her wardrobe. Point 11 states that staff are to check the IDC is free of kinks, secured to the leg strap and attached to the urine bag. 27 [Month2] … An email from [Mr B] was received on the 27 [Month2] by [RN F] and [RN C]. A heading in the email was: 'Care of Urinary Catheter'. [Mr B] stated *'I have observed that staff catheter management skills need to be improved*. *I am concerned that the leg straps need to be reviewed daily and replaced if they become ineffective'.* He goes on to state that he had seen [Mrs A's] catheter unattached to the leg and on *'each of these occasions this has led, respectively, to a complete and a partial dislocation of the IDC. This of course produced significant discomfort and pain as well as urinary leakage on both occasions. It additionally deflects the purpose of having it in place. Awareness of the signs that should alert concern of Urinary Tract Infections (UTIs) may also (historically) have been poor. This may in part be due to relative infrequency of UTIs on [the wing] but may need to be addressed. Finally, the use of barrier cream Cavilon needs to be consistently applied, after all toileting'.* The email continues and includes *'Our medium term goal is to see [Mrs A's] catheter removed and her spending progressively more time out of bed. We appreciate this is aspirational and dependent on continuing improvement of her physical perianal skin condition. Much of the above speaks to that goal and therefore I am very appreciative of your receptive and encouraging approach. I think you and your team are doing a good job and I thank*

you'. 29 [Month2], 1340 hrs … '*catheter emptied 3x in this shift and flowing well …'* Fluid balance summary sheet shows input and output.

[Month3]

1 [Month3] … IDC changed 2 [Month3] … progress notes indicate [Mrs A's] urine was cloudy and concentrated. IDC was patent and draining well there were no complaints of abdominal pain, fluids were encouraged. 3 [Month3] … The Progress Notes state: '*[Mrs A] was seen by Nurse Practitioner. Cloudy urine was noted when morning medications were given. [Mr B] (son) was insisting that I give Ural sachet as it was given last night by PM nurse due to cloudy urine. I suggested that I will let the NP review her first because of her cloudy urine as PRN charted Ural was indicated for dysuria which [Mrs A] does not show signs of or complains of. [Mrs A] does not even complain of pain or soreness on abdomen or perineal area. Ural was not given … Ensured that IDC was draining well and I noticed that urine is now clear output even though Ural was not given in the PM shift. [Mr B] (son) was complaining that his Mum was wet and catheter was leaking. I went to see and check but could not assess properly why the bed sheet was soaking wet and the continent pad is dry and the IDC line is still intact and patent. Informed CM [RN C] as [Mr B] is upset and giving RN and staff a hard time with cares and medications. Endorsed to incoming RN'* 3 [Month3] … seen by Doctor. The medical notes state: '*No rationale for prophylactic a/bs 2. Cloudy urine. I note that she has been tx 2 times in the last 6 weeks for UTI but no evidence on urine spec — only mixed growth. Son now saying cloudy with leaking and only replaced over weekend. Plan — tx with 3 days of ural sachets tds. Change catheter to one with 30 ml balloon and urine spec to lab. Son wants to discuss removal of catheter but I have reminded him of the prior issues re this. He wants to discuss clamping of catheter. I have suggested that 6 weeks' time will be good for this'.* 3 [Month3] … Email from [Mr B] expressing his concern re IDC having become unattached on the 1 [Month3]. 4 [Month3] … Urine specimen collected for urine analysis. 5 *[Month3]* … progress notes IDC draining very well. 6 [Month3] … seen by doctor for swollen gums. 6 [Month3] … The progress notes state that there was 50mls of urine output but that [Mrs A] was not showing any signs of pain. At 5.30am the caregiver reported her urine was dark-yellow to orange in colour. No blood clots were noted. 8 [Month3] 1100hours … The progress notes state that staff rang asking for a more senior nurse following a request by [Mr B]. When the RN attended, [Mr B] was removing the sling from [Mrs A] who was on the toilet. The notes state '*he wanted staff to transfer up the toilet which is an incorrect transfer. [Mrs A], when on the commode, has spasms which are painful and can cause her to wiggle off the toilet. I explained to [Mr B] that staff can only transfer up the toilet with the hoist and x2 staff as staff would hurt their backs …*'

The notes continue and the RN asked the facility manager who confirmed that staff must follow the 2x assist hoist policy at all times. Son had then requested to talk to the physiotherapist. 9 [Month3] … Progress notes (3 pages) from the day shift indicate that an event occurred in which staff and [Mr B] disagreed in relation to care and support for [Mrs A]. [Mr B] reported that his mother was in pain and staff asked her and she denied being in pain. The event appears to be around [Mrs A] opening her bowels. 12 [Month3] … seen by an NP 13 [Month3] … Progress notes indicate IDC draining well with clear urine. This continues to be the case until 22 [Month3], when it

is stated that the urine is pinkish and cloudy again and to push fluids. 17 [Month3] … email from [Mr B] discussing the use of the tilt commode. 20 [Month3] … seen by Dr re eye drops 24 [Month3] … Progress notes state that [Mr B] was concerned that, when he arrived in the morning, [Mrs A] was cold and that the window was left open overnight. The notes indicate that the IDC was leaking. 24 [Month3] … Entered in the family/whanau contact record: *'9.20am received text earlier on from [Mr B] regarding how he found his mother at 7.30am wet, cold and without call bell. Called him back to advise that I will be investigating'.* <u>25 [Month3]</u> 10am … Discussed with [Mr B] face to face, regarding the above incident yesterday. Preliminary findings — that we will follow up further notes plus action plan. 25 [Month3] … Seen by doctor for itchy perineum, pressure area is listed as static. 26 [Month3] … Email from [Mr B] to [RN D], Care Home Manager, re toileting issues which occurred on the 26 [Month3] regarding toileting times. 30 [Month3] 1.15pm … Progress notes state that [Mr B] requested a meeting with senior management re his recent concerns. He also requested the Nurse Practitioner see [Mrs A] tomorrow re pain. 30 [Month3] … the event documented in the progress notes by care staff and registered staff (3 pages) states that [Mrs A] rang the bell to be assisted to the toilet (notes difficult to read). Care staff were not able to do that at the time, as it was meal time. They advised they would be back with two staff members. [Mr B] requested the bell be kept on. The RN became involved at the request of the staff. The RN discussed the problem with [Mr B] and explained the situation regarding the call bell. Assistance was given to [Mrs A]. [Mr B] stated that [Mrs A] was in pain. A pain assessment made by the RN at this time did not identify pain. 31 [Month3] … Progress notes state urine specimen collected from IDC and sent to lab as urine described as having an offensive odour.

<u>[Month4]</u>

2 [Month4] … Lab result indicates UTI. SB Doctor who has stated — 'looked unwell' 3 [Month4] … Antibiotics commenced for UTI. STCP documented. 6 [Month4] … Progress notes indicate IDC leaking, flushed with 20mls of water for irrigation 9 [Month4] … Progress notes no reports of IDC leaking 12 [Month4] … Progress notes indicate [Mr B] very concerned re [Mrs A's] bedding and the use of a continence product. 14 [Month4] … Corrective action plan documented following a complaint re positioning, personal cares including continence and perianal care, lack of communication between staff using products and heating. Progress and evaluation documented. 15 [Month4] ... Seen by GP for rash under breast, lesion beside left eye and scalp lesions. Treatment provided for breast and scalp lesions. No treatment for eye lesion. 17 [Month4] … Medical notes state *'long conversation with family, [Mr B] on telephone re eye lesion, skin flexure care and started to talk re catheter care. Objective to meet with [Mr B] next week re ? supra pubic catheter.'* 19 [Month4] … IDC changed. Size F18 30mls in balloon. 22 [Month4] … Progress notes *'GP has a long discussion with son [Mr B] re his mother. [Mr B] was asking GP opinion re SPC & number of hours [Mrs A] goes to the chair. SPC — GP d/w [Mr B] the pros & cons & will make a referral to the urologist on Thursday. Re staying in chair: Son requests to have [Mrs A] stay in the chair longer & to change the air mattress to ordinary mattress for more comfortable positioning in bed. Appetite looks off. GP assessed that she's having UTI again, charted short course AB's. STCP done/updated*. 22 [Month4] … Progress notes 2130 hrs — IDC changed because of urine leaking. Size F18 30 mls in balloon. 23

[Month4] … Progress notes — IDC leaking. 23 [Month4] … Progress notes 1050hrs — [Mrs A] was sent to public hospital. Returned at 2145hrs. The Medical discharge letter from [the public hospital] outlines the primary reason for admission as: leaking indwelling catheter. [Mrs A] was seen by the Urology Registrar in the Emergency Department. A bladder scan showed 36mls urine present in the bladder. A manual bladder washout was completed with no clots or debris found. There was discussion re suprapubic catheter insertion and the benefits and risks of the procedure. The discharge summary indicates that [Mr B] did not want to have a suprapubic catheter inserted at this time. The discharge summary recommended a change to a size 20g catheter should leakage of urine recur. 24 [Month4] … Medical notes state: '*Long consult again with son re the catheter'.* Doctor prescribed increase in Baclofen. 24 [Month4] ... Progress notes overnight stated the IDC was leaking on 3 separate occasions. 25 [Month4] … Progress notes state that at 0815hrs [Mrs A] suffered a seizure lasting 15 seconds. Following this, she was unresponsive to any stimuli. Recordings were taken. Management of this event was discussed with son. He requested that no further recordings be done to minimize causing [Mrs A] any further discomfort. The Nurse Practitioner visited and discussed the situation with the son. Medication changed to liquid form. Staff completed a short-term care plan. 27 [Month4] Seen by the GP. [Mr B] requested that staff contact GP to visit. Staff tried to contact the GP but were initially unable to do so. When the doctor did arrive acute admission to [the public hospital] was arranged.

[Month5]

1 [Month5] … Discharge information from [the public hospital] was that the primary diagnosis was delirium secondary to an enterococcus urinary tract infection.

1. UTI — enterococcus in community — susceptible secondary to long term corticosteroids.

2. Seizure likely post stroke seizure in context of infection.

3. that alternating air mattress be removed; the clinical manager agreed to this as high-risk foam mattress is being used.

Orders were for a fluid balance chart to be commenced. Progress notes written at 2100hrs indicate that sacral area seemed to have deteriorated 2 [Month5] … [Mrs A] returned to [the rest home]. Progress notes show that catheter type was changed to rubber rather than Silicon. Son requested got worst since being in hospital. 2 [Month5] … Dr visit re increased dose of prednisone. 4 [Month5] … reported loose bowel motions, thickened fluids provided. Poor oral intake. Two hourly turns and PAC (pressure area cares) maintained. 5 [Month5] … seen by NP who feels loose BMs are due to antibiotics. NP discussed with [Mr B]. Clinical manager discussed use of bedrails and agreed to remove them. Care plan updated. Seen by Doctor. 6 [Month5] … SB Doctor — medical notes state — discussion with son. 7 [Month5] … Progress notes — [Mrs A] has vomiting episode having her medications at 1730. [Mr B] left note stating that [Mrs A] does not want bed to be lowered. 9 [Month5] … IDC draining well 12 [Month5] … Progress notes at 2105 … IDC leaking. At 22.00hrs notes indicate no further leakage. 13 [Month5] … Progress notes '*GP has been updated re sudden abdominal cramps lasting 30 seconds that comes and goes and has been chronic GP*

wants to monitor for next 2 days if cramps become more regular GP to review on Thursday.' 14 [Month5] … Staff noticed urine to be cloudy and concentrated fluids were encouraged. No abdominal pain present. 15 [Month5] … No abdominal pain reported. 15 [Month5] … SB GP for abdominal cramps IDC draining well. Urine spec to lab which indicated a heavy growth of mixed organisms 17 [Month5] … Progress notes. [Mr B] requested to see RN stating [Mrs A] was flushed and hot. Observations showed that temp was 37.6. Paracetamol was given. [Mrs A] stated she was feeling unwell. Staff contacted [medical laboratory] for IDC spec which showed mixed organisms. Doctor was contacted and advised to give Ural TDS. GP instructed to push fluids. RN noted that she felt that [Mr B] was criticising staff. Doctor contacted and stat dose of TMP (trimethoprim) given. STCP commenced. Progress notes from 2200hrs indicate that [Mrs A] was complaining about suprapubic pain at 1755hrs. PRN pain relief given [Mrs A] vomited small amount. Son concerned that antibiotics not working. [Mr B] requested [Mrs A] be seen by GP in morning if there is no sign of improvement. Staff contacted a NP and the advice was to give gastro sooth. NP advised to send [Mrs A] to [the public hospital] if family not happy with current management. Son does not want [Mrs A] to be sent to hospital. [Mr B] requested that he did not want his mother to have an anti-emetic as he thinks it will mask symptoms without treating the cause. [Mr B] requested extra paracetamol. Staff contacted NP who did not think it was clinically indicated. Notes indicate that son not happy with NP decision. Staff reassured [Mr B] re cares. 18 [Month5] … [Mrs A] admitted to [the public hospital] 23 [Month5] … Discharge information from [the public hospital] indicates the primary diagnoses were UTI and constipation. [Mrs A] was treated with AB and commenced on 2mg of prednisone with instructions to decrease. It was noted that [Mrs A] had pressure area and discharge information states daily nursing review and to be put on airbed. 23 [Month5] … [Mrs A] returned to [the rest home]. New wound was found on R forearm. Staff report right buttock cheek has redness but skin reported as not being broken. Right foot is more swollen short course of prednisone charted. IDC draining well no leaks. To continue on ABs. 24 [Month5] … Progress notes report small IDC leak. Son requested not to deflate the balloon until there is a major leakage. 26 [Month5] … IDC draining well. Staff dressed wound on right forearm. STCP documented. 28 [Month5] … Progress notes indicate that when night staff turned [Mrs A] the bed was found to be soaked with urine. At 1330 hrs the RN irrigated IDC and noted that the anchor for the IDC was stretched & tight. 29 [Month5] … Seen by GP. Included in the notes was treatment for Cefaclor for UTI prophylaxis. Swab taken from eyelids. Progress notes indicate that GP has requested that staff report every time staff flush IDC 30 [Month5] … Progress notes Staff note IDC draining well. [Mrs A] complained of suprapubic pain. PRN oxynorm given with good effect. Care staff noticed red mark on right thigh from flexi tape. RN was informed. 31 [Month5] … IDC reported to be leaking. Seen by night staff RN who inflated IDC balloon. 1500hrs [Mrs A] complained of shoulder pain, [other son] complained that [Mrs A] was not in proper position when transferred from bed to Lazyboy chair. PRN Oxynorm given. Wound dressing on right shoulder was noted to have deteriorated wound evaluation updated.

[Month6]

1 [Month6] … IDC reported to be leaking. [Mr B] found IDC bag on the floor. IDC reported not to be draining. RN documented that she was not competent with IDC management and another RN was asked to irrigate IDC. IDC reported to be draining following irrigation. 2 [Month6] … Progress notes state [Mrs A] was being transferred via hoist and RN has documented that [Mr B] was giving instructions to care staff. RN noted that this is confusing to staff. At 1600hrs RN was informed that son wanted to see RN. Notes state that [Mrs A] looked settled and comfortable. Son was concerned that output did not match input. [Mr B] requested IDC irrigation. RN reports that input from 0700hrs was 850mls and output 525mls since 0700hrs. Following abdominal assessment RN advised there was no clinical indication to complete bladder irrigation. [Mrs A] had no bladder distension, no abdominal tenderness, no report of urine leakage. RN explained to son that GP had advised not to do frequent bladder irrigations as this increased the risk of infections. Clinical manager was contacted and advised staff to contact GP, who advised to monitor output until 7 pm. Notes at 2050hrs indicate that the IDC had drained a further 200mls of urine at 1850hrs. No urine leakage was noted. Doctor contacted and he advised to contact if any other issues. 4 [Month6] … Corrective action plan documented in relation to increasing education for RNs in relation to IDC cares. 5 [Month6] … Progress notes. RN staff called to assess the anchor of the IDC on the right thigh. This had become removed. RN noticed 4 small blisters under the adhesive pad on right inner thigh. STCP commenced. Clinical manager advised. 2150hrs RN assisted with turns and noticed buttock area getting red. RN noted that skin was intact but may break down if not managed well. 6 [Month6] … Son requested morning RN review sacrum. Care staff identified that redness on sacrum was ‘*worse than yesterday*’ 7 [Month6] … Progress notes 2130 hrs. [Mr B] requested RN to review sacrum area. RN described wound as an abrasion/redness. Allevyn Life applied for protection. STCP updated. 9 [Month6] … Corrective action plan for family meeting with son re IDC care and management. IDC bag is now attached to a steel frame to avoid slipping off when secondary bag is tied and clipped on the bed. This has been handed over to all staff. 12 [Month6] … Doctor visit. Medical notes state *‘family meeting with son [Mr B] and [advocate]. Discussion re 1. IDC. 2. Catheter management if continued. 3. Management of morning medications. The Plan was to contact [Dr I] for instructions re need for IDC — she has extensive contact with [Mr B] and has recommended IDC but it would help to have documentation. […] to contact urology nurse catheter specialist re management plan if IDC remains and ? visit to rest home for instruction. [Mrs A] to have breakfast at 0900 to 0930hrs and personal care between 0930 and 1000hrs …’* 14 [Month6]–15 [Month6] … Progress notes state that dressing was required on sacrum. This was applied by evening RN. On the 15 [Month6] the RN has documented that HCA reported there was no dressing on [Mrs A’s] bottom, but when the RN checked there was allevyn on right buttock. Notes indicate that son [Mr B] was upset because the dressing had been placed on the red area of the buttock. No documentation was found concerning the dressing. The RN then applied a dressing to both buttocks. No leakage reported from IDC. 16 [Month6] … Progress notes state that [Mrs A] was sleepy at the start of the shift. When she awoke, [Mrs A] complained about generalised body pain. Pain relief was administered. 17 [Month6] … GP visit re medication changes, neck rash and deteriorating sacral wound. Notes indicate GP was arranging for [Mrs A’s] admission

to hospital. Medical notes state that break down of the sacral area had occurred … with subsequent rapid deterioration. The GP discussed the situation with the hospital specialist who confirmed she would seek urgent wound care nurse input and failing this would admit [Mrs A] to hospital. 21 [Month6] … Family meeting with GP, management and [Mr B] present. The notes indicate a formal letter from [Dr I] re the long-term use of an IDC be requested. In addition, nursing staff were to contact the Urology Nurse for advice and assistance with any IDC problems. [Mrs A's] cares to be provided between 9am to 10am. The goal to keep [Mrs A's] quality of life a priority was set. A second meeting with RNs was to be held to discuss these objectives.

Summary

[Mrs A] had an Indwelling urethral catheter long term. She was admitted to [the rest home] with this and throughout her stay there were problems relating to the catheter and catheter cares. At times the catheter became displaced and there were issues around positioning of the catheter tubing and bag when in bed and on the chair. The notes show that there were times when the IDC functioned well. At other times, leakage of urine from around the catheter was a problem. The initial care plan outlined cares and supports needed. The long-term care plan was more informative. Medical staff and nurse practitioners were, in my opinion, aware of the concerns and care issues with the management of [Mrs A's] IDC, although they would, in my opinion, have limited knowledge of the experience and skills of the care staff that provided the daily cares. My experience is that many long-term IDCs do present a nursing challenge. It is not uncommon for them to block, particularly if fluid intake is at times limited. When there are multiple medical problems as in [Mrs A's] case, these may add to the difficulties with catheter management. Urinary tract infections are a common side effect of long term IDC use. In my opinion, clinical notes show that when [Mrs A] became unwell, appropriate intervention occurred. The notes also show there were times when [Mr B] asked for urine to be checked and a specimen sent to the laboratory. Medical staff was kept informed. When the lab results indicated infection, treatment was commenced. Medical staff endeavoured to not use antibiotics unnecessarily as this might lead to the establishment of resistant organisms. Similarly, staff tried to limit the number of times the catheter was irrigated, as this may increase the incidence of infection. Medical staff at [the rest home] and [the public hospital] suggested a suprapubic catheter for [Mrs A] but this was declined by the family. Evidence shows that family had a number of meetings — both formal and informal — with nursing staff, medical staff and visiting nurse practitioners. Admissions to [the public hospital] were arranged when clinically indicated. Registered staff knowledge in relation to IDC cares appears to have been inconsistent, with some staff having appropriate clinical knowledge to provide cares and carry out procedures when necessary. Other staff, however, had limited knowledge. Daily personal cares were provided by health care assistants who showered, washed, dressed, assisted with meals and fluids and provided the support required over a 24hr period. Health care assistants would have positioned the IDC tubing following showers, toileting etc. and would contact the registered nurse if they had concerns.

The progress notes are generally well documented by care staff and registered nursing staff. Most of the entries by the care staff are very thorough. However, there are omissions in relation to specific events, e.g. how the catheter became dislodged soon

after admission. Evidence is available to show that they did seek advice and contacted the RNs when necessary. Events that occurred such as initially keeping the catheter bag on top of the bed, poor placement of the catheter tubing, allowing the IDC bag to hang thus causing pressure on the IDC itself, incorrect positioning of the tubing while the patient was in the hoist and not securing the day bag on the side of the bed causing the catheter to pull, in my opinion, show lack of knowledge and practice. This was identified early in the admission. There are comments and emails from [Mr B] with respect to this, and in my opinion, this was an area which should have been actioned soon after admission. Education should have been provided to care assistants in a more timely manner e.g. in [Month1]/[Month2]. Registered Staff, also in my opinion, should have had additional education in relation to IDC care in a more timely manner. Identifying the concerns in [Month6] appeared to be as a reaction to events rather than a proactive approach to cares and support. A quality improvement initiative could have been used to show an improvement process which would have been in keeping with the complaints policy.

Communication with the family is evident in the clinical notes. Family appeared to visit frequently and regularly. [Mr B] appeared at times to direct staff in relation to cares and support. Progress notes state that at times the registered staff and care staff felt intimidated. His request for IDC irrigation which was against the advice of medical staff obviously caused concern for staff. His complaints and concerns in relation to IDC cares were, in my opinion, justified at specific times as they related to specific events. However, some of the requests and demands on staff made it difficult for staff to feel comfortable around him. Progress notes, in my opinion, show that staff were willing to work with [Mr B]. Senior staff could have accessed outside intervention such as education for all staff who had contact with [Mrs A].

It is my opinion that the IDC cares, on the whole, met an acceptable standard. However, the events which [Mr B] identified to the facility and which were documented in the clinical notes, would be viewed as a mild to moderate departure from acceptable standards by my peers, simply due to the fact that a staff education programme, introduced sooner, may have prevented these events from occurring.

The adequacy of wound management and pressure area cares

[Mrs A's] risk of skin breakdown was, in my opinion, high. She was immobile, had multiple medical problems and had been on long term steroids, apparently for arthritis. She suffered from faecal incontinence at times and had a long-term indwelling catheter in situ. The care plan interventions on her discharge from [hospital] state, under the heading of pressure area management, — '2hrly–4hrly pressure area checks. Red excoriated skin on sacrum — monitor same.' Under wound care it states: 'Nil dressing — monitor sacrum: apply prescribed creams as charted.' Documentation is clear in relation to skin care, pressure risk and wound care. The initial care summary states that [Mrs A] bruised easily — a side effect of long-term prednisone. Staff were instructed to use 'spoon hands' when turning [Mrs A] and turns should be 'blades and hips.' It also included that all personal cares must be by two health care assistants. The interRAI completed on the 30 [Month1], stated that there was increased risk of skin breakdown due to immobility and hemiplegia. It also

stated that [Mrs A] had intermittent redness in skin folds under breasts, abdomen, and in groin/perianal area. This was treated with creams charted by the GP. Assessment was undertaken at admission and the care plans outline appropriate interventions. The progress notes clearly show that staff was aware of the possibility of development of pressure areas and appropriate pressure relieving devices were used. [Mrs A] was limited to time in the chair. Medical staff were aware of skin issues. The GP notes from 23 [Month1] state: '*still perineal itch and pain with large BM this am. Still inflamed shiny skin on perineum … I am loathe to go to strong steroid cream …'* On the 25 [Month3] '*c/o sore itchy perineum, also pressure area is now static'* on the 15 [Month4] *'asked to see to review three things 1. Rash under breasts, 2 lesion beside left eye, 3 scalp lesions*'. Wound care plans were documented for each wound. The initial wound assessment and wound management plan were thorough, including areas such as wound identification, cause, wound type, wound location, risk factors for healing and pain assessment. The second part of the wound management plan outlines the primary dressing and frequency of dressing changes. The wound evaluation was documented each time the dressing was undertaken and allowed staff to monitor the wound to show improvement or deterioration. A short-term care plan supported the wound care plan. Each wound had a separate short term care plan. The progress notes show that staff documented skin cares on daily basis. Examples in the notes include statements such as: *'creams for vagina and rectal area*,' *'creams applied by RN',* 1 [Month2]: '*sacral and perineal area is improving', 2 [Month2] … 'Consent for photograph of perineal area as part of wound management plan signed by EPOA'.* [Mrs A] was provided with an air mattress at the time of her admission from [the public hospital]. In [Month5], [Mrs A] was admitted to [the public hospital] with delirium secondary to urinary tract infection. On her readmission the Care Manager stated in the notes: *'[Mr B] (son) requested for the alternating air mattress to be removed. I have agreed to this as she is already on high risk foam mattress'.*

An accident and incident form was documented following a return from public hospital on 23 [Month5] when staff noticed redness on the right buttock. Also included was documentation for a skin tear that occurred at [the public hospital]. Other accident/incident forms were documented for blisters caused by the use of flexi-trak. On the 15 [Month6] an incident form was completed following a dressing that was applied incorrectly. On the 14 [Month6] at 1330hrs, the progress notes state: *'wound was checked on buttocks d/w [Mr B], left wound dressing off excoriated area'.* On the 15 [Month6] the HCA reported that there was no dressing on [Mrs A's] bottom. When the RN checked the allevyn dressing was on the R. side of the buttock. The RN who applied the dressing stated that she was not the RN in that area. She had been asked to dress [Mrs A's] sacrum by another nurse, who advised her that she did not have time to apply the dressing. The dressing was applied at 2145hrs. In her statement she stated that, in retrospect, she wished she had applied two allevyn dressings. No wound care plan was completed. On the 17 [Month6] [Mrs A] was seen by the GP and sent to [the public hospital]. The Medical notes state: *' breakdown of sacrum again, … sacral region rapidly deteriorating, Irritated neck skin into folds … Spoke with [Dr I]— she will attempt to arrange urgent wound care nurse for tomorrow, if she is not able to do this then for admission …'*

Summary of wound care and pressure area care.
In my opinion, the documentation shows that staff was aware of the risks of skin breakdown and pressure area development. [Mrs A] was initially admitted to [the rest home] with a red and excoriated sacrum. [Mrs A] had several events while at [the rest home] in relation to skin irritation, redness and skin breakdown. When new events happened I believe that the documentation shows that staff acted appropriately and informed medical staff of such events. Her admission to [the public hospital] was appropriate and timely. The incident that occurred on the 14 [Month6] in relation to the sacrum dressing was unfortunate and may have exacerbated the breakdown, but staff in my opinion carried out appropriate interventions following this. A referral to specialist wound consultant would have supported staff in their care planning. It is also noted that [Mrs A] was on an alternating air mattress which in my opinion was the appropriate choice for her. Following a return from hospital her son asked that this be removed which staff allowed. Overall I am of the opinion that my peers would view the pressure area and wound care as being a mild departure from acceptable standards.

The timeliness of seeking external clinical review for [Mrs A]
I believe the clinical notes show that medical staff and nurse practitioners visited on request and had reasonable knowledge in relation to [Mrs A's] nursing cares and medical conditions. Medical notes do indicate that [Mr B] spoke at some length with the doctor on several occasions. Doctor's notes from 17 [Month4] state: '*long conversation with family [Mr B] on telephone re …'* On the 22 [Month4] they state: '*discussion with son lengthy re possibly a suprapubic catheter that they are keen to consider*'. On the 24 [Month4]: '*Long consult again with son re the catheter'*, and on the 6 [Month5]: '*discussion with [Mr B] her son'.* It may have assisted nursing staff to have had specialist input from a wound care nurse and a continence nurse advisor, but in saying this there were several visits from nurse practitioners who have the appropriate knowledge and skill to advise staff. Overall I believe the clinical notes viewed show that external clinical reviews were undertaken. I believe my peers would view [Mrs A's] care as being within acceptable practice.

The appropriateness of the environment (hot room)
It is acknowledged by all involved that the room temperatures at times were excessively hot and hence made it uncomfortable for patients, and I would also suggest for staff. Ideally temperatures should be around 18–22 degrees C. Evidence is available to show that room temperatures in [the wing] reached nearly 30 degrees C at around 1400hrs. On the 5 [Month5], room and corridor temperatures exceeded 30 degrees C, with the corridor temperature at 35.5 degrees C.

Older people are at high risk of developing heat-related illness because their ability to respond to summer heat can become less efficient with advancing years and associated multiple medical conditions. It also must be noted that some immobile patients are unable to remove themselves from excessive heat and/or remove bedding which exacerbates their discomfort. Dependent patients rely on staff to provide cool fluid to maintain hydration and comfort when the environment is unduly hot. It must also be noted that it is uncomfortable for staff to work in these hot

temperatures. The facility undertook a risk assessment of this issue and identified it as a high risk to patients. Preventive measures were taken and these were appropriate. UV blocking film was added to the windows and this was noted to have made a significant improvement. It is also noted that staff recorded temperatures to demonstrate to senior management the specific issues in relation to the heat. It is my opinion that generally day to day care staff do not have input into issues like this, and that it is the responsibility of senior management of the organisation to ensure that adequate heating and cooling is provided for the safety of both patients and staff. In my opinion, the nursing staff did all they could do to address the problem, and this would be viewed as acceptable by my peers.

The appropriateness of staffing levels

It is noted that [the wing] held 8 residents. [Mrs A] was a hospital level care resident and as such would have required a higher level of care and support than a rest home level resident. She required two staff to assist with any transfers and required one staff member to assist with meals and fluids. [The wing] had two care staff on the morning shift and one care staff on the afternoon shift. Two Registered Nurses were available on the morning shift and two Registered Nurses available till 2100hrs, after which time one RN was available overnight.

Staffing levels appear to meet the guidelines for staffing. It is noted that staff working constantly in specific areas get to know their residents/patients well and are thus able to provide very individualized care. Often when these staff are away on holiday/sick leave, residents/patients and their families miss that personal care from the staff they know so well. It is noted that [the external agency's] report, dated 2018, notes that there has been a recent change and that there is now consistency for healthcare assistants in the area that they work. Although the rosters do look consistent over the time [Mrs A] was a resident, it cannot be said with any certainty that there was continuity re cares. Some care staff may have been asked to assist with hoist transfer when they had little knowledge of the processes and correct transferring techniques. I am of the opinion that staffing levels appear to meet the guidelines for staffing and would be viewed as acceptable by my peers.

The appropriateness of the care and oversight provided by the Clinical Manager

The Clinical Manager, [RN C], generally worked Monday to Friday, 8.30am–5pm. It appears from the rosters that she did every second weekend on call. Evidence is available to show that communication was undertaken with [Mr B] both through email and face to face communication. Staff also noted in the progress notes when the Clinical Manager was contacted in the event of a verbal request by [Mr B]. [RN C] worked alongside the Facility Manager, [RN D], and there is documented evidence that emails responding to [Mr B] were cc-ed to either party. The Care Manager's report shows that she was aware of daily events when on duty. In my opinion, it would be both the Clinical Manager's and the Facility Manager's responsibility to have initiated the extra education in relation to IDC management and hoist transfers when concerns were raised by family soon after admission. I believe that the failure to do this would be viewed as a mild departure from acceptable standards by my peers.

The appropriateness of the communication with [Mr B] when he had concerns/made complaints

Communication from [Mr B] and responses from Bupa are as listed. 7 [Month1] … email from [RN C] 9.39am to [Mr B] re care plan 7 [Month1] … email from [Mr B] 3.09pm to [RN C] re tentative care plan 8 [Month2] … email from [RN C] at 5.51pm to [Mr B] re care plan 8 [Month2] … email from [RN F] at 6.43pm to [Mr B] re tentative care plan 27 [Month2] … email from [Mr B] at 14.05pm to [RN F]/[RN C] re management of medications, bowels, transfer technique and IDC cares. 3 [Month3] … email from [Mr B] 11.58am to [RN F] and [RN C] re IDC concerns over weekend. 4 [Month3] … email from [RN F] at 10.22pm to [Mr B] re copy of care plan indicating amendments have been actioned. 17 [Month3] … email from [Mr B] at 1.09pm to [RN C]/[RN D] re eye care. 17 [Month3] … email from [Mr B] at 1.44pm to [RN C]/[RN D] re commode — observations and comments. 21 [Month3] … email from [RN F] at 12.52pm to [Mr B] re eye drops. 21 [Month3] … email from [Mr B] at 9.21pm to [RN F] re purchase of eye drops. 22 [Month3] … email … at 1.21pm to staff re [Mr B's] concerns re eye drops. 23 [Month3] … email from [RN F] to staff re [Mr B]/eye drops. 26 [Month3] … email from [Mr B] at 7.01pm to [RN D] re personal cares/timing of cares. 26 [Month3] … email from [RN D] at 7.46pm to [Mr B] acknowledging email. 27 [Month3] … email from [Mr B] at 7.02pm to [RN D] re toileting cares and wait times. 8 [Month4] … email from [Mr B] at 1.22pm to [RN D] re soft wipes/skin cares. 8 [Month4] … email from [RN D] to [Mr B] at 2.03pm re soft wipes/response to previous email. 10 [Month4] … email from [Mr B] to [RN D]/[RN C] at 8.48am re soft wipes. 14 [Month4] … email from [Mr B] at 2.55pm to [RN D] re cares over past weekend. Enclosed was a five page letter outlining concerns, six bullet points noted. 14 [Month4] … email from [RN D] at 5.26pm to [Mr B] responding to previous email/letter advising that she would be away and recommending a meeting in [Mrs A's] room with RNs and caregivers. 15 [Month4] … email from [Mr B] at 9.46 am to [RN D]/[RN C] re [Mrs A's] cares over the past weekend. Ongoing concerns re wound management. 15 [Month4] … email from [RN D] at 10.42pm to [Mr B] addressing email re cares over weekend. 16 [Month4] … email from [Mr B] at 11.55pm to [RN D]/[RN C] re cream for skin condition. 9 [Month5] … email from [RN D] at 12.24pm to [Mr B] re moving rooms for [Mrs A]. 9 [Month5] … email from [Mr B] at 12.45pm to [RN D] re moving rooms. 9 [Month5] … email from [Mr B] at 5.05pm to [RN D] re room temperature. 10 [Month5] … email from [Mr B] at 11.30am to [RN D] re complaint regarding IDC care and management. Photo included. 12 [Month5] … letter from Bupa to [Mr B] acknowledging receipt of email 10 [Month5]. 29 [Month5] … email from [Mr B] at 9.08am to [RN C], [RN D] re concerns relating to [Mrs A's] eyes, fungal skin infection, personal cares and IDC leakage. 29 [Month5] … email from [Mr B] at 7.20pm to [RN C] re afternoon phone call, doctor's visit and six points re care. 4 [Month6] … email from [Mr B] at 7.13am to [RN C] (2 pages) re concerns relating to IDC, and cares. 9 [Month6] … email from [Mr B] at 10.44am to [RN C] re IDC removal and wound management. 20 [Month6] … Letter from Bupa to [Mr B] acknowledging letter of complaint dated 14 [Month4]. 24 [Month6] … Letter from Bupa to [Mr B] in response to letter dated 4 [Month6]. 31 [Month6] … Letter from Bupa dated 31st [Month6]. [RN C] (Acting Care Home Manager) to [Mr B] in response to his letter dated 15th [Month6]. Also a letter dated 31st [Month6] formally acknowledging receipt of letter dated 4th[Month6]. 20 [Month9] … Letter to [Mr B] from Bupa — acknowledgment of

letter sent by a Bupa staff member. I have been unable to read some of the letters/emails due to the correspondence being illegible.

Summary

Communication between Bupa and [Mr B] was both verbal and written. The progress notes and medical notes state the times when staff communicated with [Mr B]. Reasons for the communications were also given. The family/whanau contact record has limited communication summaries. Written communications from [Mr B] were frequent. The majority of the emails are directed to senior management staff. Responses from Bupa are provided but at times the response was delayed e.g. the letter dated 14 [Month4] from [Mr B] was initially answered in an informal way and it was not until 20 [Month6] that a written response was received. The Complaints Management policy states that: There is an expectation that all complaints will be satisfactory resolved within a maximum of 20 working days. The site/service area manager is responsible for ensuring all complaints are thoroughly investigated, documented and responded to. Under the section 'Actions taken or recommended': Learning actions or recommendations identified as a result of a complaint investigation must be shared with the team i.e. at staff meetings, quality forums etc. In my opinion, my peers would find the communication between [Mr B] and Bupa of an acceptable standard, with the exception of the complaint on the 14 [Month4] when the reply was delayed until the 20 [Month6]. I would view this delay as a moderate departure from acceptable standards.

10. The overall standard of care provided to [Mrs A]

[Mrs A's] admission information shows a client centred plan with an appropriate, thorough assessment, with goals identified and interventions documented. Progress notes demonstrate care needs and her responses to the care given. The progress notes are clear and thorough in explaining the support provided and the issues which arose around [Mrs A's] care needs. [Mrs A] had a number of reviews from either the doctors or nurse practitioners. These occurred on: [Month1] — 16th, 18th, 23rd, 25th, [Month2] — 1st, 27th, 30th, [Month3] 3rd, 6th, 12th, [Month4] — 3rd, 7th, 15th, 17th, 22nd, 24th, 25th, [Month5] — 2nd, 5th, 6th, 12th, 15th, 17th, 29th and [Month6] — 12th, 17th, 18th. I am of the opinion that the standard of care was acceptable with the exception of the delay in staff being provided with education around indwelling catheter cares and transfers using the hoist. I believe my peers would find this a minor departure from acceptable standards.

11. The adequacy of relevant policies

All policies presented in the documentation received are appropriate and are in keeping with the policies of most aged care facilities. The policies, in my opinion, would meet the standards for certification and if followed by staff would ensure a reasonable level of competent clinical care.

12. The appropriateness of follow up remedial actions undertaken by BUPA

[The rest home] acknowledged that there had been care issues that could have been improved. A corrective action plan was documented outlining education requirements for staff. The actions were carried out and progress and evaluation completed. Appropriate education was provided to both registered staff and senior care givers. It

is appropriate to see that a 'moving and handling month' focused on use of available equipment. Having a month where staff focus on one topic allows staff to fully immerse in the topic and understand each resident's needs. [An external agency] carried out an audit of [the rest home] [in] 2018. [The] summary identified that of the seven criteria assessed, four were fully attained and three were partially attained. The partially attained criteria were rated a low to moderate risk. They identified training needs in areas such as InterRAI, wound management and dementia care. They found that family communication records lacked sufficient detail of the discussions that had taken place between staff and family members. Call bells were not always answered in a timely manner. Corrective action plans that specifically addressed areas for improvements following complaints were not sufficiently developed. A month later, a follow up audit was undertaken [in] 2018. This audit found the care plans were appropriate to the resident's individual identified risks and that care plans were amended as necessary. She found that the staff roster allowed staff to deliver the resident's care plan and that it allowed flexibility when care needs increased. It was also found that staff who carried out cares were competent to deliver the care with all registered nurses having attended education in catheter management, wound care and pressure injury management. Falls management training was currently being undertaken. In summary, she found no concerns at her visit in regard to resident safety or quality of care.

Summary
It is my opinion that the work which the facility has undertaken in relation to education and quality improvement will ensure a safe environment for residents and patients.

13. Any other comments you may wish to make.
From the evidence I have read, including correspondence from Bupa and [Mr B], plus the clinical notes and medical notes, I am of the opinion that there were areas of concern in relation to the IDC cares and transferring with the hoist. As I have identified in the body of this report, education at an earlier time may have prevented this from occurring. In saying this, I believe that apart from the issues identified, [Mrs A] received a reasonable standard of care. From the clinical progress notes staff have documented that at times they found [Mr B] to be very critical of cares they were delivering. This was confirmed by senior management at the Multidisciplinary Meeting which was held at [the public hospital]. When the working relationship with staff and a patient's family begins to deteriorate, it is often helpful to arrange input from various specialists outside of the facility. Towards the end of [Mrs A's] admission to [the rest home], the advice of [public hospital] specialists was sought. In my opinion, it would have been helpful to have requested the input of a Geriatrician, a Wound Care Nurse Specialist and a Catheter Care Nurse Specialist much earlier. This may have well have guided [the rest home] team in their care planning and delivery, and helped allay the concerns that [Mr B] was experiencing.

Jan Grant RN"

The following further advice was obtained from RN Grant on 6 May 2019:

> "I have revisited the clinical notes and the information you sent me re communication between [Mr B] and staff.
>
> I acknowledge that there was a response to emails sent on 14 [Month4] and a further response sent at 10.42pm the same day.
>
> In light of the evidence presented and confirmed I wish to change my opinion to state that in my opinion there was an acceptable level of communication in a timely manner between [Mr B] and Staff. I am also of the opinion that my peers would view this as consistent with acceptable standards."

The following further advice was obtained from RN Grant on 20 June 2019:

> "My view is that once the relationship with [Mr B] became difficult for the staff, management should then have initiated specialist advice from [a] Geriatrician. It is noted that the meeting with DHB representatives was after [Mrs A] had left Bupa. Clinical notes indicate that in [Month5] there were a number of concerns. Support from outside specialists would have supported the organisation and [Mr B] at this time.
>
> In relation to the hoist transfers I believe that education in [Month1]/[Month2]/[Month3] would have been appropriate for care staff. Around this period was when [Mr B] had concerns in relation to toileting etc."