Registered Nurse, Ms D

A Retirement Home

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC12520)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

This case relates to the care provided to Mr A while he was a resident of a Retirement Home (the Home) from 17 September to 12 November 2006, and 3 January to 23 April 2007.

During the first period, Mr A was admitted for respite care following carpal tunnel surgery. Despite regular dressings to his hand and an assessment at an emergency department, no documentation was completed by the Home. On 12 November 2006, Mr A was admitted to hospital with a severe infection to his hand, and he remained there until 3 January 2007, when he returned to the Home.

In April 2007, skin tears on Mr A's legs became infected, and he was subsequently readmitted to hospital on 23 April 2007. He was later discharged from hospital to another rest home.

This report focuses on the documentation, planning and delivery of Mr A's care, and considers the actions taken by staff of the Home (in particular the owner and manager, Ms D) immediately prior to his three admissions to public hospital on 1 October 2006, 12 November 2006 and 23 April 2007.

Parties involved

Mr A	Consumer
Ms B	Complainant/ Mr A's daughter
Ms C	Complainant/ Mr A's daughter
Ms D	Provider/owner, manager and registered nurse at the Home
Ms E	Registered nurse
Ms F	Registered nurse
Ms G	Caregiver

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Complaint

On 16 July 2007, the Commissioner received a complaint from Ms B and Ms C about the services provided to their father, Mr A, by a retirement home. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mr A by the Home from 17 September 2006 to 23 April 2007.*

An investigation was commenced on 3 September 2007.[1]

Following review of the information obtained, on 23 January 2008 the investigation was extended to include:

- *The appropriateness of the care provided to Mr A by Ms D from 17 September 2006 to 23 April 2007.*

Information reviewed

Information has been received from:

- Mr A's daughters, Ms C and Ms B
- Ms D
- Registered nurse Ms E
- Registered nurse Ms F
- Caregiver Ms G
- Mr A's GP
- The Home
- Another rest home
- The District Health Board
- Age Concern

Independent expert advice was obtained from a nurse specialist in elderly care and rest homes, Ms Jenny Baker.

[1] The period to be investigated initially covered 1 December 2006 until 23 April 2007, but on 12 November 2007 this was extended to include the whole period of Mr A's stay at the Home.

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Information gathered during investigation

Chronology

Background
Mr A (aged 82) had carpal tunnel surgery to his left hand in January 2006, and his wife assisted him during his convalescence. Further carpal tunnel surgery on his right hand was planned for 17 September 2006, but in the meantime Mr A's wife had died. It was agreed that he would be admitted to the Home for convalescent care after the operation.

In its publication *Resident information book for rooms* (27 January 2003), the Home is described as a 69-bed licensed retirement home, with no private hospital beds. At the time, three registered nurses were employed: Ms D, Ms E and Ms F.

Ms D and her husband are shareholders and directors of the retirement home company. Ms D is also the Manager of the Home. References in this opinion to the Home include the retirement home company.

The Home — 17 September 2006
Mr A had his carpal tunnel surgery at a private hospital on 17 September, and returned later that same day to the Home. He was to stay there on a short-term basis, and was a "private" resident, meaning that he did not receive any subsidy towards the fees charged by the Home.

Mr A's daughters, Ms C and Ms B, do not recall any form of admission process for their father, or any paperwork being completed. Ms D provided a copy of a short-term contract for Mr A's stay from 17 September 2006. The copy provided was not signed by Mr A, either of his daughters, or Ms D, although it contained family contact details and personal information about Mr A, such as his likes and dislikes and interests. There was no record of his medical history or the medications he was prescribed. Ms C holds enduring power of attorney for personal care and welfare and property (although these were not in effect as Mr A was competent). Ms B is a practising registered nurse.

Mr A's daughters stated that the nursing staff at the Home were fully aware that their father would have wounds that would need to be re-dressed after surgery, and he would also require some assistance with his care, as his hand would be bandaged. Mr A's daughters expected that the care provided to their father would include referral to a doctor if required. Mr A's daughters advised that their father's hand was regularly re-dressed by nursing staff.

Ms D stated that, after discussion with the family, it was concluded that Mr A would keep his medication in his room "as he was an independent gentleman".

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Admission to hospital — 1 October 2006
On the afternoon of Saturday 30 September, Mr A developed haematuria (blood in his urine), and by 2am on 1 October he was unable to pass urine. The Home stated that his daughter, Ms C, was "immediately" telephoned and she took her father to a public hospital at 9am. No doctor was called by the Home to see Mr A.

In contrast, Ms C stated that she was called by Ms D at 9am. It was agreed that Mr A would be taken to hospital accompanied by a member of the Home's staff, as Ms C would not be able to take her father because of her family commitments. Accordingly, Ms C met her father at the public hospital. Given that the Home invoiced Mr A for the cost of a staff member taking Mr A to hospital, Ms C's recollection appears more accurate.

The note supplied to the public hospital by Ms D stated:

> "Blood in urine since Sat PM … passing clots also. Has had this before and was investigated in Hosp."

Mr A stayed in hospital for the day, and was taken back to the Home that evening by a member of the Home's staff. The discharge letter stated that Mr A should return to hospital if he developed further bleeding or was unable to pass urine. Mr A was also referred for a urology clinic appointment. The letter also described Mr A's medical history and his ten current medications.[2]

In a letter to this Office dated 29 November 2007, Ms D stated that Mr A had carpal tunnel surgery to his left hand on 9 October 2006. She added that, on his return to the Home, "staff were required to cut up his food, dress, undress, shower, and provide assistance with footwear, transferring and walking". In an interview, Ms D repeated this claim:

> "Initially when [Mr A] came in it was only for a couple of weeks, purely because he had had carpal tunnel surgery and his daughters wanted to make sure that he had proper meals and so forth because his wife had just recently passed on. So the original arrangement was only for about two weeks. They extended that by another week and then he went into hospital for a second operation."

Mr A's daughters stated that no such operation took place in October. There is no evidence to show that this surgery took place. As stated above, Mr A had surgery to his left hand earlier in 2006, when his wife was able to assist him, and surgery on 17 September to his right hand.

[2] Medical history: left total hip replacement, peripheral vascular disease, cerebral vascular disease. Medications: dipyridamole, bendrofluazide, paracetamol, codeine phosphate, doxazosin mesylate, simvastin, citalopram hydrobromide, aspirin, multivitamins, potassium chloride.

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Injury to hand

Mr A was admitted to a public hospital on 12 November with a deterioration in his condition, secondary to a severe infection in his right hand. He remained in hospital until 3 January 2007.

The Home has provided five different accounts of how Mr A injured his hand and the period leading to this admission to hospital. No documents such as care plans, nursing notes, or medication lists were kept in relation to Mr A's time at the Home from 17 September to 12 November 2006. The absence of documentation makes it difficult to be certain of how the injury was caused, or the subsequent actions of staff at the Home in response to the injury.

Account 1

In her letter to this Office of 9 September 2007, Ms D stated:

> "On Saturday 16 December [Mr A] sustained a skin tear to his right hand by banging his hand on the bedroom wall. When questioned how, he stated he was a very restless sleeper."

Ms D stated that the dressing was renewed daily because of "ooze", and went on to describe how, on the next day (which she stated was 17 December), "the wound had no change", and on the following day (described as 18 December), Mr A's "right hand was swollen and that the wound looked infected". Ms D stated that Ms C was contacted, "who took her father for medical attention as he was still under his own GP's care".

Account 2

In her subsequent letter to this Office of 29 November 2007, Ms D stated that Mr A caused the injury to his hand on 8 November 2006, when he "caught his right hand and caused a skin tear" while he was "shaking his razor out of his ranch door to remove whiskers". The tear was cleaned and dressed with paraffin gauze. On 11 November Mr A caused a further injury to his hand by banging it on the wall, and by 12 November it was swollen and inflamed.

RN Ms E stated that Mr A's hand was dressed, and "it seemed to be healing quite fine". However, Ms E said that when she came to review the wound on "Tuesday morning"[3] the hand looked infected, and she immediately telephoned Ms C, who came to the Home and took her father to public hospital.

[3] "Tuesday" would have been, by Ms E's account, 13 November; Mr A was admitted to public hospital on Monday 12 November.

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Account 3
On 7 January 2008, the Home provided a copy of a statement signed by caregiver Ms G. The statement is headed "Saturday 16th December 2006", but there is no date when it was signed. Ms G stated:

> "That particular morning when I arrived at [Mr A's] room with his breakfast tray [he] showed me his hand injury which had occurred the previous night. It definitely needed immediate attention and I reported to [Ms D] who [accompanied] me straight away back to [Mr A's] room.
>
> [Ms D] asked [Mr A] relevant questions regarding his hand wound. His reply was he hit his hand against the wall of his bedroom during the night.
>
> [Ms D] made many suggestions; one was to turn his bed around so [no] damage would occur in the future but [Mr A] would not agree to his bed being re-positioned. I dressed his wound and the issue was then on going between [Ms D] and the [Registered Nurse] who commenced work approximately 8.30am."

Ms G was contacted to clarify her statement. She stated that she wrote the statement at Ms D's request a "few weeks" after the event. When it was put to her that the date had to be incorrect, Ms G stated that she had looked in the "communications book" to ascertain the date. There are no details of any treatment provided.

Account 4
The Home has produced an incident form dated 8 November 2006. A caregiver stated on the form:

> "Went to [Mr A's] room as his bell was ringing. Found him in his bathroom trying to stop the wounds from bleeding too much. Blood all over floor of his bathroom.
>
> …
>
> I only saw one wound on either arm/hand."

The form was signed by Ms D on 8 November. The sections that relate to informing family and doctor are blank. The form includes the question whether the incident was preventable ("Yes/No") and, if "Yes", "what has been done to prevent a recurrence". This section of the form is blank, and there are no details of the treatment provided.

The incident form was provided to this Office on 11 January 2008, some months after it was originally requested on 3 September 2007. In her response to the provisional opinion, Ms D stated that this form had been "placed in a separate file and once it was located it was forwarded [to HDC]".

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Account 5
In the transfer letter dated 12 November 2006, written by Ms D to the public hospital Emergency Department registrar, Ms D stated:

> "[Mr A] had a fall on [8 November] and sustained some skin tears to his arms. In the night of [11 November] he was very restless and hit his right hand on the wall while in bed. The hand is now sore and swollen plus he is not balancing on his legs very well."

There is no record of what treatment was provided to the wound.

Account from Mr A's daughters
Ms C said that she may have been informed on 8 November that her father had knocked his hand in the night. However, neither Ms C nor Ms B recall being informed of the alleged incident while "shaking his razor" (see Account 2), or of their father's fall on 8 November that resulted in skin tears (see Accounts 4 and 5). Ms C stated that she did not, and could not, have taken her father to hospital (see Accounts 1 and 2).

Ms C recalls being contacted by Ms D on 12 November with the news that her father's condition had deteriorated. Ms C instructed Ms D to send her father by ambulance to hospital. This is supported by a St John's Ambulance form, which states that Mr A was collected from the Home and taken to public hospital.

Ms C asked Ms D why she had not contacted a doctor to review her father. Ms C was told that, as Mr A was not a permanent resident of the Home it was the responsibility of the resident or the family to arrange for medical review. Ms B and Ms C advised that it was their expectation that a doctor would be arranged by the Home if necessary.

The ambulance form records that Mr A had fallen four days earlier, and that he had been restless for the past one to two nights. It was noted that his right hand was "swollen and dressed", and that he also had a dressing on the left arm. The form added: "Rest home staff also state [that Mr A] is not walking as well as normal". Mr A's blood pressure was noted to be low (84/40mmHg).

Public hospital — 12 November 2006 to 3 January 2007
On arrival at the public hospital ED on 12 November, it was recorded that Mr A had fallen four days previously and that he had been increasingly unsteady on his feet over the last four days. He was described as being in significant pain ("Pain +++"), his right hand was swollen, and he was unable to move his fingers. His blood pressure was recorded as 74/49mmHg. The assessment of Mr A by the doctor stated:

> "Swollen ++ hand [to] mid forearm [with] cellulitis
>
> some movement at wrist/fingers — limited by pain"

A later assessment noted that Mr A's right hand had started to "swell and get sore" the previous day.

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Mr A had an operation at 11.59pm to explore his right hand. The surgeon recorded:

> "Large area of grossly purulent material affecting [back] of hand — superficially [a] large collection just deep to skin."

Mr A had further operations to debride the wound, and skin grafts were subsequently placed on his right hand (8 December 2006). He was transferred to the care of the geriatric team for rehabilitation, and eventually discharged back to the Home on 3 January 2007.

Ms B stated that her father had sustained skin tears on other occasions but that they had never become infected. She said that Mr A was "devastated" by the infection, by the many operations and treatments required, and by the loss of function.

The Home — 3 January to 23 April 2007

When Mr A returned to the Home on 3 January 2007, the wound care plan from the hospital stated that the dressing on his hand was to be changed every third day. His hand was subsequently re-dressed on 6 January with a plan to review it the following day. There is no record of dressings that were used, or the condition of the wounds, from Mr A's return on 3 January until a wound treatment chart was commenced on 13 January.

Hospital admission — 7 January 2007
The clinical record completed by Ms F states that she was asked to assess Mr A at 11.30am on 7 January as he was having "rigors" and pain in his right hand. Ms F performed clinical observations and found that he had a raised temperature (38.3°C), and his blood pressure was normal at 120/77mmHg. At 1pm, Mr A complained of pain in his right ear and the top of his neck; Ms F repeated the blood pressure and found that it had dropped to 104/48mmHg. Accordingly, Ms F called an ambulance and contacted Ms B to inform the family of their father's condition.

Mr A was transferred to the public hospital's emergency department.

The admission assessment in ED noted that Mr A had developed diarrhoea overnight, and treatment was commenced for gastroenteritis.

Following further treatment in hospital, Mr A was discharged back to the Home on 11 January. His hand still required dressing. Wound treatment charts were completed for 13, 15, 17, 19, 20, 22, 25, and 26 January.

A falls risk factors score card and a gerontology nursing assessment form were completed on 9 February. The falls risk was assessed as a score of 23. (A score above 10 is considered a high risk.) A pressure risk assessment and a care plan were completed on 10 February.

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Injury to leg — 16 April 2007
On 16 April, Mr A was taken on an outing by his daughter, Ms B.

While out, Mr A sustained skin tears to his right thigh and lower right leg.[4] Ms B dressed these skin tears (she is a practising registered nurse), but advised the Home's staff that the upper skin tear would require re-dressing the following day.[5]

An incident form was subsequently completed by Ms F. She stated that she returned to the Home two or three days later to complete the form (she has dated it 16 April). Ms F stated on the form that Ms D had been advised of the incident, and the form is signed by Ms D, with the date 17 April.

The clinical record of 17 April records that the wounds were reviewed and "appear to be healing". The next entry in the clinical record is not until 21 April.[6] In a subsequent statement made after receipt of the complaint, Ms E recorded her care on 19 April:

> "... I reviewed [Mr A's] skin tear wounds. The upper thigh wound appeared sloughy with slight redness on the surrounding skin, I took a swab and redressed the wound … The lower leg skin tear appeared clean, no sign of infection, the graze appeared to have broken down so I applied a dressing to both wounds …"

There is no contemporaneous record of a swab being taken on 19 April.

On 21 April, the dressing was renewed by Ms G, caregiver. No descriptions of the wounds were recorded.

On 22 April, Ms F recorded that the wound at the top of the leg was "sloughy and slightly pink" around the edges. She recommended that a wound swab be taken the following day to check for infection.

Later that day, at 3.20pm, Mr A fell off his bed, and suffered a skin tear to his right arm. The incident form completed by Ms F recorded that Mr A had "some difficulty mobilising". Ms F recorded that he had "full movement … can stand", but he did not wish to walk. Ms F recorded that the clinical observations were stable (there is no record of the measurements) and that Ms D and Ms C were informed of the fall.

[4] There is some confusion as to how the injury occurred, with the incident form dated 16 April (but not completed on that day) stating that the injury was caused by a heater being accidentally dropped on Mr A's leg. Ms B stated that the injury was caused by a walking frame and that the confusion may be due to the fact that she was buying a heater for her father at the time.
[5] No wound treatment chart was completed for this injury.
[6] In the period from 3 January to 23 April 2007, the progress notes were not completed on 44 occasions: 12, 15, 17, 21, 23, 24, 27, 28, 31 January; 1–4, 6–9, 11, 18, 19, 21, 25 February; 1, 4, 6, 11, 14, 16, 18, 20, 22, 27, 28, 30 March; 1, 4, 6, 8, 9, 16, 18–20 April.

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23 April 2007
On the morning of 23 April, Ms E was asked by the caregivers to review Mr A as he appeared generally unwell and was able to walk only a few steps. He had "slurred speech … he had normal power in his limbs, no complaints of pain, no nausea, and was breathing normally". Ms E reported her findings to Ms D.

An hour later, a caregiver asked Ms E to review Mr A again, and she found him disorientated and incontinent. Ms E stated that she took Mr A's temperature, finding it raised (38.25°C) and she checked the wounds on his legs. She stated that the wounds were "sloughy with redness around the peripheral skin area". Ms E said that she telephoned the laboratory to check the results of the wound swab she had taken on 19 April. The result was sent to the Home by fax (timed at 10.53am).

The swab result showed a heavy growth of the bacteria Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Streptococcus pyrogenes*. Ms E informed Ms D of the results and stated that she (Ms E) attempted to contact Ms B; as she was not available, Ms E said she left a message with Ms B's partner.

In contrast, Ms B states that she was telephoned by Ms D to say that Mr A's condition had deteriorated. Ms B was told that her father had not been seen by a doctor since the injury to his leg, and that there was now infection. Ms B advised Ms D to call an ambulance immediately. An ambulance was called to take Mr A to hospital. Ms D advised (having contacted St John's Ambulance Service) that the ambulance was called at 11.24am, and arrived at 12.24pm.

Admission to hospital — 23 April 2007
At 1.20pm, Mr A was admitted to the public hospital accompanied by a member of staff from the Home. Mr A was commenced on intravenous antibiotics and admitted to hospital. The admission record states that Mr A was discussed with the Home's staff, and that Mr A's right leg had been "swollen and erythematous [red]" for the past two days.

On 3 May, Mr A was transferred to another public hospital for surgical removal of necrotic (dead) tissue on his right leg. Unfortunately, his condition deteriorated, and a subsequent amputation of his right leg was performed on 7 May.

Mr A was transferred back to the first public hospital on 14 May, and finally discharged to a private hospital on 1 June 2007.

Other matters

The Home
The Home provided a copy of a document entitled *Resident information book* (27 January 2003). In relation to medical services, the document states:

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> "All residents have choice of their own doctor. Our Doctor maintains a weekly visit and will see all residents on a regular basis. It is Ministry of Health requirement that all medical records and care records must be kept at [the Home]."

In relation to medication, the document states:

> "Medications are controlled by the nursing staff and are strictly monitored to ensure that your medication is dispensed safely and correctly … **The self medication is only permitted under staff supervision**."

In relation to admission procedures, the document states:

> "The home has [a] comprehensive admission pack for gathering personal and medical information of incoming clients. This is a requirement by Ministry of Health that each resident entering our facility must fully fill in this pack and return it to the manager. On admission the manager will give you this pack and it is yours or next of kin or agent's responsibility to ensure that they are filled in completely and handed over to the manager as soon as possible."

Medical review

In her response to the provisional opinion, Ms D explained why a doctor was not called prior to Mr A's three admissions to hospital:

> "GPs carry out home visits between surgery times i.e lunch times or after day time surgery hours. There are some GPs who refuse to do home visits to the rest home insisting families take the client to the surgery. Therefore it was in the best interests of Mr A to transfer him to hospital rather than wait for the GP to visit and therefore delay medical attention."

Roles and responsibilities

Ms D describes her role as "Manager/RN" or "Registered Nurse Owner", while her husband is responsible for "administration".

The Home provided job descriptions for the positions of Registered Nurse (updated 16 September 2007), Manager (dated October 2000) and Registered Nurse (Owner) (updated 1 February 2008).

The Manager job description includes the following responsibilities:

> "…
>
> <u>To plan [and] implement ongoing care direction</u>
>
> Congruent to government health service focus and change, and that complies with all aspects of the contract held between the Ministry of Health and the rest home, the 'Standards for Rest homes and Hospitals 2002', the 'Health and Disability Services (safety) Act 2001' and any other required compliance that may occur from time to time.

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…

To ensure completion of all nursing documentation, general records and daily administration duties."

The Registered Nurse (Owner) job description includes the following functions and responsibilities:

"…

1. Working with staff to prepare a written comprehensive care-plan for each resident. The care staff in the home will be expected to adhere to the care-plans, which may include such things as ambulating, continence training, measures to avoid physical, mental and social deterioration and other matters relevant to the individual.

…

4. To manage delivery of safe, efficient and therapeutically effective nursing care by delegation, good prioritisation of personal and collective workloads.

…

8. Maintenance of clinical records. The RN will start new admission nursing care plans and do any others as required. It is expected that written communication to staff is well maintained. Training of staff to ensure that they adhere to care-plans."

In her response to the provisional decision, Ms D advised that it was Ms F's "delegated responsibility … to ensure that all of the paper-work for each client was put in place and maintained as current". Ms D added that she felt that "the professional status of the RNs meant that it was not necessary to constantly check on the system and what they were responsible for".

Wound treatment issues

Ms D stated that the Home renewed dressings as required, but that Mr A was known to remove them and expose his wounds. Ms D also stated that Ms B would visit and renew Mr A's dressing without consulting Home staff and using rather "complex, expensive dressings". Ms D said that dressings were found in Mr A's room that were not the dressings used in the Home. She said that Ms B would visit her father, entering through his ranch slider, not making her presence known to staff. In contrast, Ms B advised that she may have "tidied up" the dressings on Mr A's hand once or twice but had never re-dressed it. She stated that she had not visited in the week between him injuring his leg and being admitted to hospital, as she had been moving house (16–23 April). Ms B provided copies of the relevant pages from her diary, which supported this recollection.

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Policies
The Home's wound management procedure (dated 14 August 1999) described the signs of an infected wound, which included "redness … pain … inflammation … raised temperature", and fast heart rate. In relation to skin tears specifically, the procedure states:

> "If the surrounding area becomes red and warm there is the possibility that there may be an infection. In that case the doctor will be asked to have a look at it and most likely we will dress the skin tear (infected) with Bactroban for a few days and an oral antibiotic might be necessary."

Documentation
The total documentation provided by the Home for Mr A's admission from 17 September to 12 November is the unsigned short-term contract, an incident form dated 8 November 2006, and two invoices dated 9 October and 9 November 2006. Ms D explained the reason for there being no care plan for the period from 17 September to 12 November 2006:

> "[Mr A's] daughters state[d] … that their father was an independent man requiring only a minimal amount of care with his aids to daily living. No formal care plan was put in place."

Ms D added:

> "In this industry English is often a second language for the caregivers. Our caregivers are kind and caring. They prefer, and learn best, by being shown everything regarding the care needs of the residents. As a result of English not being their first language in many cases, many could not comprehend an elaborate care plan or wound care plan — hence their simplicity. The staff are more aware of the resident's physical and spiritual needs than could ever be documented on paper or through the written word."

In a letter dated 9 September 2007, Ms D stated that Mr A's clinical records for this period were with his GP or with Mr A's subsequent rest home. However, the GP advised in a letter dated 13 September 2007 that she did not have any clinical records for Mr A, and she had last seen Mr A in September 2006. Mr A's subsequent rest home stated that they were not sent the relevant records.

In an interview on 8 November 2007, Ms D and RN Ms E advised that no clinical records were maintained for short-stay patients, which would have included Mr A from 17 September to 12 November 2006.

However, Ms F (who has subsequently left the Home) advised that when short-stay residents were admitted, a front sheet would be completed, which included details of the resident, "their past medical history, family details and what care they required". Ms F advised that she was "certain" that there had been a front sheet for Mr A. In

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contrast, Ms D stated in response to the provisional opinion that it was not policy to complete a front sheet for short-stay residents as described by Ms F. Ms D assumed that Ms F was referring to the short-stay contract, which contained such information.

Ms D provided a copy of Mr A's unsigned Resident Contract Form for short-stay residents. In the section related to the conditions of accommodation and care it states:

> "…
>
> 4. This Home is licensed and staffed as a home for the elderly and not a hospital. In case of illness, we seek assistance and advice from a doctor.
>
> …
>
> 10. From time to time it may be necessary for the residents to attend a specialist, X-ray, medical Centre, Dentist, Hospital and other such appointment. It is your or your next of kin or agent's responsibility to make necessary arrangements."

Ms F stated that the documentation for short-stay residents was kept separate by Ms D in a folder in her office. Ms F recalled that Ms D advised both her and Ms E that documentation on a daily basis was not necessary, and that she did not like to waste paper. Ms F said:

> "If [Ms D] said you don't do it, then you don't do it."

In her response to the provisional opinion, Ms D clarified this. She stated:

> "[A]s short stay residents were only occupying rooms for a minimal amount of time and, further, that these clients were well and able to maintain their own care, there was less intervention and consequently less paperwork. In many cases, the respite client only needed meals, oversight for medication and a place to sleep whilst family members whom they lived with were away."

Ms F also stated that she and Ms E were told by Ms D that, before they contacted a doctor or an ambulance for a resident, they should call her first. However, Ms D stated that no registered nurse had been told to seek her approval before obtaining medical attention for any resident when it is clinically indicated. Ms D added:

> "It is common practice that the RN discusses any decline in a resident's health with [Ms D] if she is on site, and then makes the necessary arrangements. This is not because an RN has to seek approval for their actions but it is a matter of respect for the manager as the person who is ultimately responsible for the residents and accountable to their families."

In the conclusion of her response to the provisional opinion, Ms D accepted that there was a lack of documentation for the care provided to Mr A from September to

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November 2006. However, she denied that the documentation for the subsequent period was substandard. She stated:

> "It is our considered opinion that there were no breaches of the Nursing Code, nor was the care that was given inappropriate in the circumstances. We can assure the Commissioner that [Mr A] did receive good quality care. Where we failed is that we did not document this."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Other relevant standards

Ms Jenny Baker, who provided independent expert advice in this case, has referred to a number of applicable standards. These are detailed in her report (see **Appendix**). In her advice Ms Baker refers to the Ministry of Health contract for aged care. As Mr A was not a subsidised resident at the Home, the provisions of this contract do not directly apply. However, I accept that the contractual provisions are indicative of accepted standards in aged care, and are therefore helpful in considering whether the services provided by the Home were of a reasonable standard.

In addition, the following standards from the Health & Disability Sector Standards (NZS 8143: 2001) are particularly relevant:

> Standard 2.5 The day to day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate and safe services to consumers/kiritaki.
>
> Standard 4.2 Consumers'/kiritaki needs and support requirements are assessed in a comprehensive and timely manner.

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Standard 4.4 Consumers/kiritaki receive adequate and appropriate services in order to meet their assessed needs and desired outcomes or goals.

Standard 5.2 Consumer/kiritaki records are accurate, reliable, authorized and comply with current legislative and/or regulatory requirements

Code of Conduct for Nurses (Nursing Council of New Zealand December 2004):

"**PRINCIPLE TWO**

The Nurse acts ethically and maintains standards of practice.

Criteria

The nurse:

…

2.9 accurately maintains required records related to nursing practice."

Opinion

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

Opinion: Breach — Ms D

Introduction

Ms D was responsible for managing the Home and providing nursing services. She held major responsibility at the Home and wielded significant influence over the staff. In particular, I note Ms F's comment that, if Ms D said that you don't do something, "then you don't do it".

Ms D's job description states that she was responsible for the standard of nursing care as well as being involved in providing daily nursing care. In particular, she was involved in Mr A's care prior to his hospital admissions on 1 October 2006, 12 November 2006, and 23 April 2007. I do not consider that Ms D met her responsibilities in terms of ensuring that other staff provided appropriate nursing services or in providing those services herself.

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Furthermore, although Ms D stated that Ms F was responsible for the completion of documentation, in my view, as Manager, Ms D had a clear responsibility to ensure that documentation was completed and of an adequate standard. She failed to meet this responsibility. Mr A's documentation at the Home was either non-existent or of a poor standard. In the context of Mr A's care, with his requirements for assistance and wound dressings, and his hospital admissions on 1 October and 12 November 2006, the decision not to maintain clinical records in the period from 17 September to 12 November 2006 was negligent.

For the reasons set out below, I have found that Mr A was provided with substandard care in a number of areas, and that Ms D and the Home breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights. I am also of the view that the failures were of a seriousness that warrant the referral of both Ms D and the Home to the Director of Proceedings.

Admission — 1 October 2006

Mr A started to pass blood in his urine on the evening of Saturday 30 September 2006. By 2am the following morning, he was unable to urinate. The response by staff at the Home was inadequate. Although the Home stated that Ms C was "immediately" informed about this development, this is incorrect. Ms C was contacted by Ms D at 9am, some seven hours after her father had become unable to urinate, and even longer since he had started to pass blood in his urine. A doctor was not called during this time, and no documentation was completed to describe this significant change in Mr A's condition. I agree with my expert advisor, Ms Jenny Baker, that Mr A should have received medical attention during the night, and that it was "unacceptable" to leave him in urinary retention and in severe pain.

When Mr A was discharged back to the Home later that same day, the discharge letter advised that, should the symptoms recur, he should return to hospital. This was not recorded on any documentation at the Home, and there is no evidence that a care plan was completed to manage this potential problem.

Mr A was not provided with appropriate care in the period after he developed haematuria and urinary retention on 1 October 2006. A doctor should have been contacted for a medical review. The nursing documentation should have provided a detailed account of the events of 30 September and 1 October, and a care plan should have been put in place following Mr A's discharge.

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Admission — 12 November 2006

On the afternoon of 8 November 2006, Mr A injured his hand. This resulted in "blood all over the floor" — the caregiver's graphic description recorded in the incident form. This was the only record of the incident, and it was incomplete. The form did not describe the wounds in any useful detail. No clinical observations were performed either at the time of the incident or in the subsequent days to check for signs of infection. I also note that there is no contemporaneous evidence that the injury was assessed by a registered nurse. What is significant is that Ms D signed the form on 8 November. I am therefore satisfied that she was directly responsible for ensuring that this incident was appropriately dealt with.

No care plan was put in place to allow staff to treat the injury adequately. Ms Baker advised that the dressing that was used was inappropriate for a skin tear. The family was advised that Mr A had knocked his hand, but not that a significant injury had resulted. Finally, no doctor was called to assess Mr A either at the time of the injury, or in the subsequent period.

Although Mr A was subsequently admitted to hospital on 12 November, my expert advisor, Ms Baker, has advised that, given Mr A's condition, there would have been some evidence of infection on the preceding day. In particular, she notes the spread of inflammation to Mr A's arm. It is also relevant that the emergency department records state that Mr A's hand was swollen and painful on the day *prior* to admission. Ms Baker advised that, in her opinion, "[Ms D] failed in her duty of care to [Mr A] by not assessing his hand injury or his vital signs by taking observations and by not obtaining immediate medical advice and treatment."

Mr A was not provided with an appropriate standard of care from the time of his injury on 8 November 2006 until his admission to hospital on 12 November. There was a significant failure to treat, monitor, and document the injury, as well as a failure to obtain a medical review. Ms D is directly responsible for these failures as she was aware of the incident and took inadequate action.

Admission — 23 April 2007

There is some confusion about how Mr A injured his leg on 16 April 2007. Although Ms D contends otherwise, in my view the cause of the injuries is not relevant to the issue of whether staff at the Home acted appropriately to a change in Mr A's condition. What is relevant is that Ms D was aware of the injuries. She was informed on the day they occurred.

No wound care plan was put in place after the injury; this is despite knowledge that Mr A had previously suffered from a significant wound infection and the chances of such an event recurring would have been greater. Although I comment below on the standard of documentation, it is of particular concern that there is no contemporaneous record of Mr A's care on 16, 18, 19 and 20 April, when there should have been closer observation of Mr A's condition.

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Despite Ms E's comment that there were no signs of infection on 19 April, this is not entirely consistent with her statement, made after my investigation commenced some five to six months after the events. She noted that a third site (the "graze") had broken down, that she had taken a swab, and that the "thigh wound appeared sloughy with slight redness on the surrounding skin". It is clear from her account that these wounds were deteriorating and, by taking a swab, Ms E was concerned about the presence of infection. However, no clinical observations were performed and no medical review was arranged.

The dressing was renewed on 21 April by a caregiver, yet there is no evidence that the wounds were assessed by a registered nurse.

On 22 April, Mr A fell, and he was reported as having difficulty mobilising; Ms D was informed of this development, yet there is no evidence she assessed Mr A. There is no record of any clinical observations being performed, and no medical review was requested.

By the morning of 23 April, Mr A's condition had deteriorated still further. Ms D still did not contact a doctor. According to Ms B, she was contacted by Ms D and the swab result was discussed, and it was Ms B who encouraged the Home to admit her father to hospital.

It is noteworthy that, despite Mr A's hospital admission in November 2006 with a significant infection, no clinical observations were performed from 16 to 23 April; only on 23 April was a temperature recorded (38.25°C).

Ms Baker advised that a registered nurse should have reassessed the leg wounds daily from 19 April (once it was established that the top leg wound was sloughy), in order to minimise the risk of infection and to determine if and when medical intervention was required. In her view, a doctor should have been consulted at this stage. Ms Baker described the wound care provided to Mr A as "inadequate, inappropriate and substandard" and warranting severe disapproval.

I have noted Ms Baker's advice and I accept that Mr A's care from 16 to 23 April was haphazard, with no clear plan set or followed. Clinical observations were not performed, there was no plan of care for managing the wounds, and a medical review was not arranged, even though Mr A's condition was deteriorating. I note that the assessment performed in the emergency department stated that Mr A's condition had been deteriorating for the previous four days.

Documentation

Overall, the documentation throughout Mr A's residence at the Home was seriously substandard. The Code of Conduct for Nurses and the Health & Disability Sector Standards both set out a clear requirement that clear and accurate records are kept. I consider that Ms D failed to meet her responsibility as a nurse and a manager to ensure that necessary documentation was completed in planning and recording Mr A's care.

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17 September to 12 November 2006
No documentation was completed for the period when Mr A was considered a short-stay resident of the Home following his carpal tunnel operation. Although he required regular dressings to his hand, there was no plan of care and no progress notes. Although Mr A required some assistance with his activities of daily living (as his hand was bandaged) there was no record of what assistance he required. In particular, I note that Ms D noted that on his return to the Home after his surgery (which she, erroneously, dated as 9 October 2006), "staff were required to cut up his food, dress, undress, shower, and provide assistance with footwear, transferring and walking". This assistance requires a plan to allow staff to provide the best possible care.

Although Ms D provided a copy of Mr A's contract for his stay from 17 September, this contract had not been signed by Mr A, his daughters, or Ms D, and provided only the briefest of details: family contact information and Mr A's personal likes and dislikes.

Ms D gave two reasons for there not being a care plan. First, that Mr A had been, prior to admission, independent. This reasoning is irrelevant as Mr A was, because of his incapacitation following the surgery, no longer able to care for himself. Thus, in my view, there should have been a plan of care.

Ms D also advised that "staff are more aware of the residents' physical and spiritual needs than ever could be documented on paper or through the written word". Ms D added that many of the staff "could not comprehend an elaborate care plan or wound care plan". This reasoning is, frankly, bizarre. Ms D appears to be suggesting that documented care plans are not mandatory for the caregivers, as they have a full and current knowledge of 69 residents' care, and that she employs staff who are unable to "comprehend" a care plan. This is hardly mitigation for failing to have adequate documentation.

There was no record of the medications Mr A was taking, or whether he was self-medicating. Had he been self-medicating, there should have been a record of Mr A's medications, and a comment in his care plan that he was self-medicating. If he was not self-medicating, there should have been a record of the medication and of the administration of the drugs. I note that the discharge summary following Mr A's admission on 1 October 2006 provided details of 10 different drugs, and that this may have proved a complex regime to follow.

There is no record of Mr A's admission to hospital on 1 October 2006, or any record of any change to Mr A's care as a result of this admission, despite the instructions set out in the discharge summary. I do not consider that Mr A's status as a "short-term" resident provides an adequate excuse for the complete lack of documentation about his care.

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I endorse Ms Baker's view that as the documentation from 17 September to 12 November was "almost non-existent [and] extremely poor … this would be viewed with severe disapproval".

3 January to 23 April 2007
Although Mr A was discharged back to the Home on 3 January 2007, no care plan, falls risk score card or gerontology nursing assessment forms were completed until over a month later on 9 and 10 February. In addition to this tardiness, Ms Baker advised that the standard of completion was inadequate.

I also note that, in the period from 11 January (after Mr A's return to the Home from a brief stay in hospital) to 23 April, his progress notes were not completed on 44 days out of 102.

In my view, the standard of documentation from 3 January to 23 April 2007 was woefully inadequate. Assessments were not performed in a timely manner, there were significant gaps in the completion of the progress notes, and I accept my expert's advice that the plan of care was inadequate.

Medical review

Ms D stated:

> "Short stay residents are under the care of their own GP and it is therefore the responsibility of their family to take them to appointments and provide medication and medical notes."

It appears that Ms D is contending that, as Mr A was a short-stay resident, neither she nor her staff had any responsibility to arrange for a medical review of Mr A, even in an emergency. In her response to the provisional opinion, Ms D stated that it was better to transfer Mr A to hospital rather than "wait for the GP to visit and therefore delay medical attention".

I do not accept Ms D's argument that it was the family's responsibility to obtain medical review, nor do I accept the submission that it was better to transfer Mr A to hospital than arrange for a doctor to visit. There were clear indications of a need for Mr A to be reviewed by a doctor, a review which, if made earlier, may have prevented Mr A's deterioration and subsequent admission to hospital.

In my view it is clearly the responsibility of staff at the Home to call a doctor if one is required. As stated above, a medical review was required prior to Mr A's admissions on 1 October 2006, 12 November 2006 and 23 April 2007.

Although there is disputed evidence on this point, I am also concerned, as is my expert, by Ms F's suggestion that a doctor or an ambulance cannot be called unless Ms D has been called first, even in an emergency. Ms D has denied this. However, I note that such a standing order could delay medical assistance, and is therefore inappropriate.

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Summary

I am satisfied that Mr A was provided with substandard care by Ms D during his residence at the Home. In particular, I am concerned about the lapses in care during the periods leading to his hospital admissions on 1 October 2006, 12 November 2006, and 23 April 2007. In addition, the failure by Ms D to ensure that documentation was completed in relation to Mr A's care from 17 September to 12 November is, in my opinion, a severe departure from expected standards. In my view, the documentation of Mr A's stay at the Home from 3 January to 23 April 2007 was also well below a reasonable standard.

Ms D breached Right 4(1) of the Code as Mr A was not provided services with reasonable care and skill. By failing to ensure the completion of documentation to an appropriate standard, Ms D also breached Right 4(2) of the Code.

Opinion: Breach — the Home

The Home had a direct obligation to provide Mr A with services of an appropriate standard, as well as a responsibility to take reasonable steps to ensure that Ms D complied with her obligations to Mr A. In my opinion, the Home failed to discharge either of these obligations.

Direct liability
Under Rights 4(1) and 4(2) of the Code, the Home was obliged to provide services to Mr A with reasonable care and skill and in compliance with relevant standards, such as the Health & Disability Sector Standards. As discussed above, I consider that Ms D, as Manager and a registered nurse, is accountable for many of the failings in the care provided to Mr A. However, there are some areas of concern that relate more to the failure of the Home to discharge its obligations.

The Health & Disability Sector standards required the Home to assess Mr A's needs and provide him with appropriate and safe services. In my view, the Home failed to comply with these requirements. Mr A did not receive timely medical attention when he experienced haematuria or when his hand and leg wounds became infected. There is no evidence that the wounds were thoroughly assessed, and adequate care plans were not put in place. Quite simply, the services provided by the Home to Mr A were not of a reasonable standard.

As discussed above, there was almost no documentation regarding Mr A's care for the first period (of almost two months) that he spent in the Home. This lack of documentation appears to have been largely due to the Home's policy of not keeping records for short-term residents. While Mr A may have been resident at the Home on a "short-term" basis, he was there for almost two months, having had surgery, and he had needs that should have been the subject of documented assessments and care

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plans. Even when Mr A was admitted on a more permanent basis in January 2007, the documentation was of a poor standard and completed haphazardly.

My expert advisor, Ms Baker, advised that the policies and procedures that the Home made available to its staff were "a concern". More specifically, some policies were out of date and "user unfriendly". In Ms Baker's view they did not comply with relevant certification requirements. In my opinion, the Home did not have the necessary systems, procedures and policies in place to ensure that Mr A received services of an appropriate standard. Accordingly, the Home breached Rights 4(1) and 4(2) of the Code.

Other comment

Previous complaint
On 30 June 2003, the Commissioner released his findings into a complaint about care provided in August 2001 to a short-term resident of a retirement home.

In August 2001, Ms D and her husband were co-owners and co-licensees of both this retirement home and the Home. Ms D provided registered nurse support, and was recorded in the retirement home's documentation as being the Matron, and "responsible for the overall care of residents".

The Commissioner concluded that Ms D had breached the Code because, as she was the senior nursing clinician at the retirement home, she should have been aware of the deficiencies in the areas of assessment, planning, and documentation. In this earlier case, a nursing assessment and care plan were not completed throughout the 16-day admission.

As a result of the complaint, the Ministry of Health performed an audit, and made recommendations. In response to the recommendations, Mrs D's husband stated in a letter to the Ministry dated 26 November 2001:

> "The process of admitting new residents entering the home is amended to incorporate the short term care residents. The process will include the initial assessments and care plans.
>
> …
>
> Incident and accidents policy [sic] is now amended so that all accidents and incidents are properly recorded and analysed for risk assessment and rectification."

Ms and Mr D have, through findings by this Office and the Ministry of Health audit process, previously been made aware of the importance of assessment, planning and

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documentation in relation to short-term residents and recording of adverse incidents. It is very disappointing that, rather than using this previous case as an opportunity for learning and improvement, similar omissions have occurred again.

Variations in evidence
As previously noted, I have received a variety of accounts from the Home about Mr A's care, and some of these accounts are substantially inaccurate. I also note that the various accounts of Mr A's care leading up to his hospital admission on 12 November 2006 were all stated as fact, rather than assumptions or "best guesses" in the absence of documentation.

The account given by the Home about how Mr A was transported to hospital on 1 October is inaccurate. The Home stated that Ms C was contacted and she came to take her father to hospital; this did not occur. Mr A was escorted to hospital by one of the Home's staff (and Mr A was charged $50 for this service), and Ms C met her father at the hospital.

I also note that Ms D stated that Mr A was taken by his daughter to see his GP because of the infection in his hand. This also is incorrect.

Ms D also said that the reason why no swab of Mr A's hand was taken in the period 8–12 November 2006 was because "he was going for medical attention to his own doctor". This is rather more than a simple inaccuracy. Ms D appears to have concocted a story in order to justify her reasons for not taking a wound swab in the period prior to 12 November 2006.

Apology
Ms D has provided an apology, which states that she apologises for the inadequate documentation during the period when Mr A was a short-stay resident. Ms D stated that the complaint has been used "as an opportunity to re-look at the processes … in place". Ms D also advised that the complaint has been used "to train management and staff in better practices and to improve lines of communication".

Recommendations

- I recommend that the Ministry of Health perform an urgent, issues-based audit of the Home, with the emphasis on the documentation of care provided to all residents, including short-stay residents.

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Follow-up actions

- Ms D and the Home will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the New Zealand Nursing Council, with my recommendation that it consider whether a review of Ms D's competence is warranted.
- A copy of this report will be sent to the District Health Board and the Ministry of Health.
- A copy of this report, with details identifying the parties removed, will be sent to New Zealand Healthcare Providers, the Association of Residential Care Homes, the New Zealand Nurses Organisation and the Quality Improvement Committee, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix — Independent advice to Commissioner

The following expert advice was obtained from Ms Jenny Baker:

"**Report on [the Home]**
I have been asked to provide an opinion about the standard of care that [Mr A] received while at [the Home] in relation to the following questions:

Complaint
The appropriateness of the care provided to Mr A by [the Home] from 17 September 2006 to 23 April 2007.

[At this point Ms Baker notes the documents provided to her, details of the complaint made and the questions asked of her. This information is omitted from the report for the purpose of brevity.]

…

Professional Profile
I registered as a Registered Nurse in 1978. From 1978 to 1981 I worked as a Staff Nurse in Oncology. From 1981 until 1995 I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital. In 1995, I was Clinical Nurse Co-ordinator in an Assessment, Treatment and Rehabilitation Ward (A, T & R) before taking up the position of Unit Manager, A, T & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents. From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract. I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors. From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. From 2006 to 2007, I worked as a Care Manager in a rest home and rest home dementia. I currently work in a generalist medical ward and critical care unit for a DHB public hospital. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

Background
[At this point, Ms Baker repeats the background of the case, which has been omitted for the purpose of brevity.]

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…

1. Please comment generally on the care provided to [Mr A] from 17 September to 11 November 2006.

[Mr A] was admitted to [the Home] on 17 September 2006 as a privately funded respite resident, which was arranged by the family and not through the District Health Board (DHB) NASC (Needs Assessments Service Co-ordination) Service. He continued to reside as a private respite resident until his return from hospital on 3 January when he became a private paying long term resident, at which stage he was assessed by NASC on 26 January 2007.

[The Home] did not complete an admission agreement/contract for the respite care with [Mr A] and his daughter. There were no nursing documentation, such as nursing assessment and associated assessments eg falls and pressure risk, care planning and progress notes, completed by [the Home] for the period from 17 September to 11 November 2006. There is no record of medical review, medication charts and medication administration charts.

On 1 October, [Mr A] was passing blood in his urine with clots. The Rest Home Manager contacted the daughter about [Mr A] passing blood and clots and the decision was made to transfer [Mr A] to hospital for investigation; [Mr A] returned that day. The note sent by [the Home] (no date or signature whom sent the note) states: '*Blood in urine since Sat PM. Passing clots also. Has had this before & was investigated in* Hosp'. The Public hospital Discharge & Coding Summary states: *'Previous episodes of haematuria, investigated with USS and flexible cystoscopy, no cause found … Last night developed haematuria, urinary retention 0200 until 0600, severe pains in penis, finally voided clot at 0600 with urine … MSU — … no bacteria'*. I note that 1 October was Sunday and that the [the Home] note sent to the hospital documented that [Mr A] had been passing blood clots on Saturday afternoon. There is no evidence that [the Home] had a care plan in place which outlined how to manage any episodes of haematuria [Mr A] might experience. There is no evidence as to what measures [the Home] put in place to manage the passing of blood clots on the Saturday (30 September) and the urinary retention and passing of blood clots which occurred on 1 October 2006. From the sparse documentation available from [the Home], it appeared that [the Home] did not seek any medical advice or assistance at the time of the urinary retention during the night but instead contacted [Mr A's] daughter during the day to inform her of the urinary retention and blood clots and she advised that they took [Mr A] to the hospital for investigation/treatment; this contact occurred after [Mr A] had been able to pass urine with the blood clots. However, the Public hospital Discharge & Coding Summary described [Mr A] as having being in urinary retention and severe pain from 0200 until 0600 when he passed urine.

On 8 November [Mr A] was found in the bathroom bleeding from his wounds. [the Home] staff completed an Incident/Accident Report Form/Non Conformance form

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on the 8/11/06 at 2.50 pm. The form states: *'Found him in his bathroom trying to stop the wounds from bleeding too much. Blood all over floor of his bathroom. I only saw one wound on either arm/hand. Another staff member went over to do the dressings'*. The form was signed but no designation or family member notified were filled out. There is no description of the actual wounds, where they were sited exactly and what caused them. The form was signed by the Rest Home Manager on 8/11/06; she had not completed the section of the form which states: *'was this incident preventable? Yes/No. If Yes, what has been done to prevent a re-occurrence'*. [The Home] did not complete a wound assessment or short term wound care plan for the skin tears, however, [Ms D], Manager stated in her 17 November 2007 letter to Rae Lamb, Deputy Commissioner: *'8 November … This was cleaned and dressed with paraffin gauze'*. The handwritten note on page 00166 (no date or signature of whom wrote it) stated: *'This was cleaned & dressed with paraffin gauze'*.

On 11 November (? correct date — ? should be 12 November), [Mr A] had deteriorated and the Rest Home Manager contacted his daughter to inform her. The daughter advised that [Mr A] should be transferred to hospital. The Rest Home Manager wrote a letter dated 12/11/06, to the A & E Registrar which states: *'This man had a fall on the 8-11-06 & sustained some skin tears to his arms. In the night of the 11-11-06 he was very restless & hit his right hand on the wall while in bed. The hand is now sore & swollen plus he is not balancing on his legs very well*. The [DHB] ECC Assessment Nursing form 12/11/06 states: *'Fell 4/7 days ago, sustained skin tears to (L) elbow and (R) wrist … (R) hand swollen. Unable to move fingers … Time 1100; Temp 36.9; Pulse 82; BP 74/49; Resps 18; O2 Sat 97'*. [DHB] clinical notes states: *'AM 12/11/06 (R) hand — swollen/red/painful … afebrile … (R) Hand — swollen ++ hard, mid forearm with cellulitis … Imp: cellulitis (R) hand; 12/11/06 2130 Problems 1. Septic shock. 2. Hypotension. 3. Anuria. 4. 2* to infected hand'*. There is no evidence of an Accident/Incident Form/Non Conformance form for the 11/11/06 being completed. There is no evidence of a pain or wound assessment and pain or wound care plans completed.

My opinion

The lack of documentation by [the Home] during this period of time means that I am unable to determine how much care and its appropriateness that [Mr A] received generally during the timeframe 17 September to 11 November 2006; however, I am able to comment on some specific areas. Please refer to Question Six for further comment re the standard of documentation.

It is not common practice for rest homes to complete admission agreements/contracts for respite care, nor is it a requirement for the subsidised resident under the DHB's Respite Care Contract 2005, which I believe that [the Home] was ethically obliged to follow for private paying respite residents. Please refer to Question Three for further comment.

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As [Mr A] was a private respite resident and under private respite it is generally accepted that the resident remains under their own GP with family responsible for taking the resident to visit the GP for normal and non urgent visits. For urgent medical care the residential care facility is responsible to ensure that the GP is contacted by their staff and requested to visit the resident at the facility. Please refer to Question Nine for further comment.

In relation to [Mr A's] urinary retention with severe pain, it is unacceptable to leave a person in urinary retention and in severe pain without seeking medical advice and assistance. It was unacceptable for [the Home] to wait until during the day to contact the daughter to discuss and request the daughter to obtain medical attention for [Mr A]. The caregivers should have contacted the on call Registered Nurse for advice and assistance. I would have expected the on call Registered Nurse to have made a decision to either have contacted the on call GP to discuss the situation and for the GP to come in to attend [Mr A] or alternatively to have called an ambulance to take [Mr A] directly to hospital. It would be usual in this type of situation to have contacted [Mr A's] own GP first (or on call GP after hours as in this instance) and allowed them to make the decision as to whether he would be reviewed in hospital or alternatively for the GP to assess [Mr A] and possibly insert a catheter in order to wash out the bladder of blood clots, in the rest home. I would not expect a Registered Nurse to catheterise [Mr A] to do the washout unless they were trained and clinically competent to do so, and this would be unlikely as traditionally men have been catheterised by doctors or specially trained Registered Nurses only. [Mr A] should have received medical attention during the night when he was in urinary retention and severe pain. In my opinion, [Mr A] received a lack of care from [the Home's] Nurse Manager and Registered Nurses for the urinary retention and passing of blood clots episode, as they left [Mr A] in severe pain for four hours; this lack of care would be viewed with moderate disapproval. Please refer to Question Nine for further comment in relation to urgent medical attention and Question Two in relation to the Nurse Manager's standard of care.

There is no evidence of any pain assessment being completed on [Mr A] when he complained of pain in his right hand. Registered Nurses should be assessing pain using a pain assessment form; however when a Registered Nurse responds to an acute situation the Registered Nurse may choose to document the pain assessment within the progress notes rather than on a pain assessment form. In [Mr A's] case, there were no progress notes or any nursing documentation at all provided for [Mr A] during the period from 17 September to 11 November 2006. This lack of assessment would be viewed with slight disapproval.

In relation to the skin tear on the right hand and the further injury to the right hand, I believe that [the Home's] Nurse Manager and Registered Nurses did not give [Mr A] appropriate care initially on the 8 November 2006 or during the period of the next few days until he was admitted to Public hospital. [The Home] Nurse Manager

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and Registered Nurses did not assess the skin tear adequately nor utilise the correct dressing required. Please refer to Question Seven for further comment.

I noted that the right hand sepsis was caused by E Coli, a bacteria which is present in the bowel and is usually associated with urinary tract infections; this indicated to me that the wound was not dressed in a manner that made it occlusive and that [Mr A] obviously needed care and attention when he participated in any hygiene requirements, particularly when he moved his bowels, to ensure his hand hygiene was not compromised and to reduce any risk of infection. (Refer to page 00202 [DHB] notes: *'23/4/7 … Previous scn (? word) sepsis R) hand — E coli'*). In my opinion, that indicates to me that [Mr A] did not receive adequate care from the caregivers with his ADL's (Activities of Daily Living) and that the Nurse Manager/Registered Nurses did not complete a nursing care plan for the caregivers to follow, ensure that the dressings were occlusive, remained intact and did not review the dressings daily. Daily dressings would have been required due to the position of the dressing and the fact that [Mr A] would be using his hand, washing it, etc. This would be viewed with moderate disapproval. Please refer to Question Two for further comments on the Nurse Manager's standard of care and Question Seven for wound care.

2. Please comment on the standard of care provided by [Ms D].

[Mr A's] urinary retention with severe pain and blood clots event on 9 October 2006 was discussed under Question One. At the time of this event, which happened during the night without a Registered Nurse on site, I am concerned about whether [the Home] had an on call procedure for caregivers to follow and whether the caregivers contacted a Registered Nurse. The DHB Aged Care Residential Agreement for Subsidised Residents states: *'D17.7 d. Strategies and/or protocols shall be operational to ensure that advice and/or support is available to On Duty Staff at all times, should the need arise'*. [Ms F] outlined 'the calling doctors in an emergency procedure' as stated in the Complaint Action (page 00161): *'In relation to calling doctors in an emergency, stated that [Ms D] told her and [Ms E] that they should call her before calling a doctor or an ambulance'*. Ethically [the Home] and [Ms D] are responsible to ensure that the private paying residents, including respite, receive at least the same level of care as the subsidised residents. Assuming [Ms F's] statement to be correct, then [Ms D] is placing an unnecessary barrier to obtaining urgent medical advice/attention in a timely manner and making it more difficult after hours, particularly at night.

[Mr A] injured his right hand on 8/11/06, which [Ms D] was aware of as she signed off the Accident/Incident Form/Non Conformable form. [Mr A] apparently re injured his hand by hitting it against the wall on 11 November 2006. The Description of Care Provided to [Mr A] from 17 September to 1 December 2006 (page 00061) states: *'11 November 2006. [Mr A] cause further injury to his hand by banging it on his bedroom wall at night'*. A notation by [Ms G] — Caregiver dated Saturday 16th December, 2006 (page 00037) states: *'[Mr A] — Hand Injury. That particular morning when I arrived at [Mr A's] room with his breakfast tray*

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[Mr A] showed me his hand injury which had occurred the previous night. It definitely needed immediate attention and I reported to the Nurse/Manager who accompany me straight away back to [Mr A's] room. The Nurse/Manager asked [Mr A] relevant questions regarding his hand wound. 'His reply was he hit his hand against the wall of his bedroom during the night.' The Nurse/Manager made many suggestions one was to turn his bed around …. I dressed his wound and the issue was then on going between the Nurse/Manager and the Registered Nurse who commence work approximately 8-30 am.'. I note the dates of these notations are not consistent with events, however due to the description within the notations I am assuming that they are about the same incident.

The Transcript of Interview [Ms D] (page 00014) states the following: '[HDC Investigator]:… *In reference to the skin tear of his right hand, you say that, and I will quote from this "that he was assessed ([Mr A] was assessed) and a dressing applied by one of the registered nurse ([…])"; [Ms D]: I didn't actually apply it, it was [Ms G]. The lady that has written the letter;… [Ms D]: I just made the suggestions because of his restlessness sleeping, could we turn his bed around, a different angle than how his daughters had arranged it because he was just hitting that hand and I suggested'*. From this transcript, it is clear that [Ms D] did attend [Mr A's] re-injury of his hand as requested by the caregiver, did not conduct a wound assessment or plan for [Mr A's] hand injury and that she left it to a caregiver to decide on what the wound required. It appeared that [Ms D] was more interested in how a further injury could be prevented, which is important and relevant, but secondary to the injury itself rather than the immediate wound assessment, plan of care required and an assessment of [Mr A] to determine why he was so restless. A simple assessment of [Mr A's] hand should have determined that the hand and wrist were swollen and inflamed which would have indicated infection and would have required urgent medical attention.

[Mr A] was apparently admitted to hospital on 12/11/2006, not 11/11/2006. [DHB] ECC Assessment form patient label states: *'Date: 12/11/2006. Time 10.31'*. A letter dated 12-11-06 from [Ms D] to the A & E Registrar reiterates this date. It states: *'This man had a fall on the 8-11-06 & sustained some skin tears to his arms. In the night of the 11-11-06 he was very restless & hit his right hand on the wall while in bed. The hand is now sore & swollen plus he is not balancing on his legs very well'*. The Description of Care Provided to [Mr A] from 17 September to 1 December 2006 (page 00061) states: *'12 November 2006. [Mr A's] hand in the morning was noted to be swollen and inflamed. An ambulance was called at 9.24 am to take [Mr A] to [public] hospital … [Mr A] was in the hospital until discharged on 01/12/2007'*. [Mr A] was admitted at this time with septic shock secondary to an infection in his right hand and was subsequently discharged back to [the Home] on 3/1/07. It is clear from the significant deterioration in [Mr A's] hand that the hand must have been infected prior to him knocking his hand on the night of the 11 November 2006 and that he most likely knocked his hand due to restlessness from the infection and pain he must have been suffering from.

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I note in the Transcript of Interview of [Ms D], Nurse Manager, with Ms E, [HDC Investigators] in attendance, that [Ms D] commented twice on [Mr A's] TIA's that he was apparently experiencing whilst in [the Home's] care as stated: *'[Ms D]: Because he had many TIA's he was on aspirin as well as Persantin. I think he continued to have those TIAs and at times he would show signs of early dementia or confusion, aggression, mixed up …* [HDC Investigator]*: And he had no TIAs with you when he was here. [Ms D]: Well the only evidence that we would have if he had a TIA was that he would be irritable. There was no deficit in his movements or anything but I think it was just his personality. There would be a bit of aggression and so forth'*. There is no evidence medically that [Mr A] was having continual TIAs, the [DHB] Discharge & Coding Summary states: *'Admitted: 19/12/2006 … Secondary Diagnoses … Cerebral vascular disease; Admitted 09/01/2007 … Secondary Diagnoses … CVA'*. It is not stated that [Mr A] had continual TIAs. The Discharge & Coding Summary do state under Secondary Diagnoses for both admissions: *'Cognitive Impairment MMSE 22/29'*, which indicates that [Mr A] would possibly show early signs of dementia usually associated with short term memory loss. [Mr A] could exhibit the type of behaviour described by [Ms D] if he was unwell, was in pain or had an infection. There is no evidence, due to lack of documentation, that [Ms D] completed any type of assessment on [Mr A] or requested a medical review when he was exhibiting this behaviour in order to determine what was causing the behaviour to occur.

[Mr A] was readmitted on 3 January 2007 to [the Home]. I note that there is a notation by [Ms F], Registered Nurse for an event that occurred on 7/1/07. As there appears to be an inconsistency with the date of this event and [the] DHB's records of admissions, I have discussed this, including [Ms D's] responsibilities under Question Sixteen.

[Mr A] was apparently admitted to [public] hospital on 9/1/07 with gastroenteritis and discharged back to [the Home] on 11/1/07. There is no notation within the progress notes to state that [Mr A] had this problem and that he was admitted with it; the progress notes had stated that [Mr A] was admitted on 7/1/07 with an event that appeared to be related to his right hand. The progress notes state: *'7/1/07 12.00 At approx 11.30 was called to assess [Mr A] who was at that time having rigors. He c/o of intense pain in his Rt hand … ambulance rang again … Informed the hospital on covering letter how I hadn't been able to contact family'*. The subsequent notation in the progress notes states: *'11/1/07 11.00 Returned from [public] hospital following episode of Gastroenteritis'*.

There is no evidence that [Ms D] gave adequate care to [Mr A] in terms of his wound care, care planning, medical review or falls when she was directly involved or ensured that adequate care was given when indirectly involved. There are no progress notes for [Mr A] from 17 September to 11 November 2006 and from 26 February to 2 April 2006. There is no documentation within the progress notes on 18, 19 and 20 April, during the period of time in which the Registered Nurses were apparently not on duty. [Ms F] stated in her letter to [HDC Investigator] received

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15 Jan 2008: *'I asked about the dates in the progress notes for April 2007 when nothing was written. [Ms F] stated that this was probably when neither she nor [Ms E] was present. [Ms F] worked during 1–2 days in the weekends during this time but had school holidays off which were from the 9th April–22nd April 2007. [Ms F] said her understanding was that [Ms D] would have completed documentation in those instances'.*

My Opinion

[Mr A] was a privately paid respite resident from his admission on 17 September 2006 and then became a privately paid long term resident on 3 January 2007. [The Home] must comply with and provide care for the subsidised resident as outlined in the DHB's Respite Care Contract 2005. [The Home] should ethically provide at least the same level of care for a private respite resident that they provide for a subsidised resident; this includes assessment, care planning and medical review when required. The Licensee/Nurse Manager is obliged to ensure that this care is given to the resident; this clearly did not happen in [Mr A's] case. Please refer to Question Three.

The DHB Aged Care Residential Agreement for Subsidised Residents that [the Home] will have sets out quite clearly what is required for a subsidised resident; there should be no difference to the care provided to a private resident. The Ministry of Health contract states under Human Resources: '*D17.2 Rest Homes e. Registered Nurse. You must employ, contract or otherwise engage at least one Registered Nurse, excluding a registered psychiatric nurse, who will be responsible for working with staff and (where that Registered Nurse is not the Manager) the Manager to: i. assess Subsidized Residents…., ii. develop and/or review Care Plans…, iii. advise on care and administration of medication…, iv. provide and supervise care…, v. act as a resource person and fulfill an education role, vi. monitor the competence of other nursing and Care Staff to ensure safe practice, vii. advise management of the staff's training needs, viii. assist in the development of policies and procedures; f. where there is more than one Registered Nurse in your Facility the duties and responsibilities assigned to the Registered Nurse may be shared between the Registered Nurses On Duty over a 24 hour period'*. The Ministry of Health Contract D17.2 d. ii. states: *'The role of the Manager includes, but is not limited to, ensuring the Subsidised Residents of the Home are adequately cared for in respect of their every day needs, and that services provided to Subsidised Residents are consistent with obligations under legislation and the terms of this Agreement'*. As Licensee/Nurse Manager, [Ms D] is contractually obliged to ensure this contract is followed, and for Private Residents, has an ethical responsibility to ensure that [Mr A] received at least the same standard of care as described in clause D17.2 and D17.2 d.ii. As a Registered Nurse, when [Ms D] was responsible for the Registered Nurse input during the times when the Registered Nurses, Ms E and [Ms F] were not on duty, she must ensure that she follows the Ministry of Health Contract as stated above. The Licensee/Nurse Manager is obliged to ensure that this care is given to the resident;

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this clearly did not happen in [Mr A's] case and would be viewed with moderate disapproval.

[Ms D] was the attending Registered Nurse on 12 November when the caregiver reported the injury at breakfast time and was the Registered Nurse who wrote the letter to the A & E Registrar on 12 November 2006 when [Mr A] was admitted with septic shock. In my opinion, [Ms D] failed in her duty of care to [Mr A] by not assessing his hand injury or his vital signs by taking observations and by not obtaining immediate medical advice and treatment. [Mr A] clearly had overwhelming infection, which would not necessarily have been expected but should have been detected very quickly and actioned. This would be met with moderate disapproval.

The procedure for contacting doctors in an emergency requiring the Registered Nurses to call [Ms D] first is not acceptable. Registered Nurses must be able to assess an acute situation and then contact the doctor for advice or request a visit. This necessity to call [Ms D] first and clearly obtain permission to phone a doctor could compromise a resident in an acute situation and leads one to question whether the Registered Nurses were allowed to call in doctors when [Mr A] was unwell before he was acutely unwell. It also raised the question of whether there was a Registered Nurse on call for caregivers to seek their advice in situations out of office hours in which they needed Registered Nurse input. I also question the Registered Nurse on call responsibilities after office hours and whether they had the delegated authority to call a doctor or ambulance during the night without contacting [Ms D] first. The necessity to contact [Ms D] thus causing delay in accessing medical assistance in an urgent situation would be viewed with moderate disapproval.

[Ms D] had overall responsibility as the Licensee/ Nurse Manager to ensure that all residents were cared for appropriately and she should have ensured that [Mr A's] hand and leg injuries and subsequent infections were treated appropriately and that he was medically assessed at the first signs of infection. [Ms D] failed in her duty of care with [Mr A's] hand injury and overwhelming infection which resulted in septic shock. In view of the rapid spread of the hand infection to septic shock, I would have expected [Ms D] to have been more vigilant with regard to the subsequent leg injury. [Mr A] was at great risk of deteriorating very quickly with subsequent infection with the leg injury; he should have been monitored very closely and any signs or symptoms acted upon immediately. [Ms D] failed to ensure that [Mr A] had appropriate and timely nursing and medical care; this would be viewed with severe disapproval.

As Owner/Nurse Manager/Licensee, [Ms D] was responsible for the care provided to [Mr A] whilst a resident within [the Home] from governance level contractually and also personally as a Nurse Manager/Registered Nurse under the New Zealand Nursing Council's Code of Conduct for Nurses and Midwives and Registered Nurse Competencies.

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3. Please comment on the requirements of a residential home, in [Mr A's] circumstances, to complete documentation.
As mentioned previously, [Mr A] was a privately funded respite care resident for the period from 17 September 2006 to 11 November 2006 and as such, [the Home] contractually did not have to comply with the DHB's Respite Care Contract 2005 for subsidised residents; however, [the Home] does have an ethical responsibility to ensure that the privately funded respite care residents receive at least the same level of care as those of the subsidised respite care residents and this includes documentation. The DHB's Respite Care Contract 2005 states the following:

'3.2 Administration: You will collect baseline information regarding the client's health status, abilities and support needs, which is updated, collated and held upon each contract of respite care services…;

3.4 Care Plan: You will ensure: 1. Each client has a written short term care plan; 3. The care plan describes the client's assessed health and support needs, so they can maintain their level of physical and social functioning'.

In relation to whether a residential home is required to establish an agreement/service contract with private respite residents there is no contractual requirement for them to do so, nor is there for the subsidised resident under the DHB's Respite Care Contract 2005. It would make good business sense to do so but the reality is that it is time consuming and given the short nature of most respite care, i.e. from a few days up to 4 weeks, it is unlikely that many facilities would do so.

For the period of time that [Mr A] resided as a permanent private resident (from 3 January to 23 April 2007); again as a private resident there is no requirement for a residential home to establish an agreement/service contract. However, the Aged Related Residential Care Contract requires residential homes to do the following:

> *D6 WRITTEN ACKNOWLEDGEMENT FROM NON-SUBSIDISED RESIDENTS*
>
> *D6.1 You must advise all Non-Subsidised Residents in writing that:*
>
> *a. If a Non-Subsidised Resident wishes to become a Subsidised Resident, he or she must satisfy the Eligible Person criteria in clause A5.2, which includes an assessment by a Needs Assessment and Service Co-ordination Service and a financial means assessment under section 69F of the Social Security Act 1964; and*
> *b. Assessments under clause A5.2 may require some time to arrange, and the conclusion of such assessments may be that the Non-Subsidised Resident is not an Eligible Person; and*

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c. You will not be able to claim payments under this Agreement in respect of that Non-Subsidised Resident until he or she has satisfied the Eligible Person criteria in clause A5.2

D6.2 You must obtain written acknowledgement from each Non-Subsidised Resident that he or she has been advised in writing of the matters referred to in this clause D6.1.

This requirement would normally be covered within an agreement/service contract.

[Mr A] was a privately paying permanent resident from his readmission to [the Home] on 3 January 2007. Ethically [the Home] was required to deliver at least the same standard of care to [Mr A] as they are required to do so for Subsidised Residents. For permanent subsidised residents the Aged Related Residential Care Contract requires:

D 13 Admission Agreement

D13.1 You must ensure that each Subsidised Resident or their nominated representative signs an Admission Agreement on the Day that the Subsided Resident commences receiving services at your Facility.

D13.3 The Admission Agreement must contain

a. A list of services that are excluded as set out in Clause D14;

b. Information about charges relating to any service or items, including the items set out in Clause D14, that are not covered by payments under this Agreement.

The Ministry of Health's contract requirements also includes:

D16.2 Assessment on Admission

You must ensure that:

a. The assessment on admission covers the physical, psycho-social, spiritual and cultural aspects of that Subsidised Resident.

b. Each Subsidised Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to three weeks, and that Registered Nurse input and agreement is sought and provided in developing and evaluating the initial Care Plan to ensure continuity of relevant established support, care and treatments;

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c. The assessment utilizes information gathered from the Subsidised Resident, their nominated representative (where applicable) and information provided by the relevant Needs Assessment and Co-ordination Service and/or previous provider of health and personal care services along with observations and examinations carried out at the Facility.

D16.3 Care Planning

You must ensure that:

a. Each subsidized resident has a Care Plan and that all staff follow the Care Plan

b. At the time of admission an initial Care Plan is documented in accordance with Clauses D16.2 (b) and (c);

c. Each care plan is developed and evaluated by a Registered Nurse within three weeks of admission of the Subsidised Resident's admission;

d. Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status;

e. The Registered Nurse who develops the Subsidised Resident's Care Plan considers the experiences and choices of each Subsidised Resident in accordance with Clauses D3 and D4;

f. Each Subsidised Resident and his or her family have the opportunity to have input into the Subsidised Resident's care planning process;

g. The Care Plan addresses the Subsidised Resident's current abilities, level of independence, identified needs/deficits and takes into account as far as practicable their personal preferences and individual habits, routines, and idiosyncrasies;

h. The Care Plan addresses personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function needs and care of the dying;

i. That a Registered Nurse is responsible for ensuring the plan reflects the Subsidised Resident's assessed physical, psychosocial, spiritual and cultural abilities, deficits and need.

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j. Each care plan focuses on each Subsidised Resident and states actual or potential problems/deficits and sets goals for rectifying these and detail required interventions;

k. Short term needs together with planned interventions are documented by either amending the Care Plan or as a Short Term Care Plan attached to the Care Plan;

l. Care plans are available to all staff and that they use these care plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

D16.4 Evaluation

a. You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier.

D16.5 Support & Care Intervention

c.iii. for each Subsidised Resident, a written and implemented social and recreational programme of activities planned to meet the identified interests, stated preferences and level of ability/disability of the Subsidised Resident. You must ensure that this activity programme is evaluated and reviewed each time the Care Plan is reviewed;

D8 Clinical Record System

D8.1 You must ensure that every Care Giver or Registered Nurse maintains a written record of progress for every Subsidised Resident under the care of that Care Giver or Registered Nurse. You must ensure that all Care Giver or Registered Nurse entries are legible, dated and signed by the relevant Care Giver or Registered Nurse, indicating their designation.

My Opinion

In my opinion although there is no contractual requirement for a residential home to establish an agreement/service contract for a long term private paying resident, apart from the Aged Related Residential Care Contract clause D6, it makes good business sense and would be advisable for them to do so not only financially but also to ensure that there are no issues which could arise later between the Private Resident and family and the residential home. It is standard practice for residential care facilities to obtain an agreement/service contract with long term private paying residents. [The Home] should have completed an agreement/service contract with [Mr A] and his family on the day he commenced receiving services as a long term private paying resident. This would be viewed with moderate disapproval.

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In my opinion, [the Home] was ethically bound to deliver at least the same level of care, which includes documentation, for [Mr A] during his tenures as a private paying respite and permanent resident. Please refer to Questions Four, Six and Twelve for further comments.

It is important to note that [the Home's] individual Registered Nurses and Nurse Manager are required to act ethically and to complete nursing related documentation in order to meet their requirements under the Nursing Council of New Zealand Code of Conduct for Nurses and Midwives which states: '*Principle Two. The nurse or midwife acts ethically and maintains standards of practice. Criteria. The nurse or midwife: 2.5 upholds established standards of professional nursing or midwifery practice; 2.9 accurately maintains required records related to nursing or midwifery practice*'. The Nurse Manager and Registered Nurses are also required to comply with the Nursing Council of New Zealand's Competencies for Registered Nurses is required in order for them to obtain and retain their Registered Nurse Certificate on a yearly basis; this includes completion of appropriate documentation. Please refer to Questions Four, Six and Twelve for further comments. **[These references to the Nursing Code of Conduct do not appear current. Since June 2006 the Code has only applied to nurses – not nurses and midwives as stated above.]**

4. Please comment on [Ms D's] responsibilities in relation to the documentation of care.

[Ms F], Registered Nurse, advised [HDC Investigator] that [Ms D] kept casual resident's documentation in her office, she didn't like to waste paper and it wasn't essential to document on a daily basis. The Complaint Action (page 00160) states: '*Stated that the casual residents would have a front sheet completed on their admission, which would include details of the resident, their past medical history, family details, and what care they required … Said that she was certain that there had been a front sheet for [Mr A] for the period when he was a casual resident… [Ms F] stated that the documentation for casual residents was kept separate by [Ms D] in a brown, A4 folder in her office, and [Ms D] specifically stated to MM and [Ms E] that she did not want to 'waste paper' on casual residents. [Ms F] stated: 'If she ([Ms D]) said you don't do it, then you don't do it'*. [Ms F's] letter to [HDC Investigator] received 15 Jan 2008 (page 00159) states: '*Thanks for reviewing this report. I will need to make amendments to the following paragraphs in order to make the information more accurate … [Ms F] stated that the documentation for casual residents was kept separate by [Ms D] in a brown A4 folder in her office and [Ms D] specifically stated to [Ms F] and [Ms E] that she didn't like to waste paper, on several occasions and that they were not a hospital, but a Rest-Home, therefore documentation a daily basis was not necessary. [Ms F] stated 'If she ([Ms D]) said you don't do it, then you don't do it'*.

As the Owner/Licensee/Nurse Manager, [Ms D] was responsible to ensure that appropriate services were delivered to [Mr A] during his tenure at [the Home],

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which included documentation of care. The DHB's Respite Care Contract 2005 states: *'3.4 Care Plan: You will ensure: 1. Each client has a written short term care plan; 3. The care plan describes the client's assessed health and support needs, so they can maintain their level of physical and social functioning; 6.2 Staff Training and awareness — Respite Care: Staff are informed about and comply with the requirements necessary for a client …; 6.4 Staff Familiar with the Intention of this Specification: You will ensure that workers employed by your organization to provide Respite Care services are orientated to and familiar with the goals of this specification and quality standards'*. Although [Mr A] was a privately paid respite care resident, in my opinion, [Ms D] was ethically bound to provide at least the same standard of services as the subsidised respite care resident is entitled to receive under the DHB's Respites Care Contract 2005. [Ms D] should have ensured that the file she did keep for [Mr A] while he was a respite resident was readily available for all staff involved in his care and not kept in her office as it was vital that nursing staff had access to [Mr A's] past medical history and what care he required. It is acceptable to keep a separate file for documentation around business matters such as fees, etc but any information which is pertinent to nursing must be kept in the nurses' office.

Once [Mr A] became a long term private paying resident, [Ms D] was ethically responsible to ensure that [Mr A] was provided with at least the same standard of services as the subsidised resident is under the DHB Aged Care Residential Contract, which also includes documentation. As mentioned in question two, The Ministry of Health Contract D17.2 d. ii. states: *'The role of the Manager includes, but is not limited to, ensuring the Subsidised Residents of [the Home] are adequately cared for in respect of their every day needs, and that services provided to Subsidised Residents are consistent with obligations under legislation and the terms of this Agreement'*.

As mentioned in question three, individual Registered Nurses which includes the Nurse Manager are required to complete nursing related documentation in order to meet their requirements under the Nursing Council of New Zealand Code of Conduct for Nurses and Midwives which states: *'Principle Two. The nurse or midwife acts ethically and maintains standards of practice. Criteria. The nurse or midwife: 2.5 upholds established standards of professional nursing or midwifery practice; 2.9 accurately maintains required records related to nursing or midwifery practice'*. The Nursing Council of New Zealand's Competencies for Registered Nurses is required in order for them to obtain and retain their Registered Nurse Certificate on a yearly basis. The Competencies for Registered Nurses also requires [the Home's] Nurse Manager and Registered Nurses to complete appropriate documentation.

In my opinion, [Ms D] failed in her duty as Nurse Manager by not ensuring that a file with nursing related information and documentation was readily available in the nurses' office and that regular documentation in progress notes was completed for [Mr A] by the Registered Nurses and Caregivers. [Ms D] failed in her duty to

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ensure that [Mr A] was assessed and a short term care plan written for his tenure as a private paying respite resident. [Ms D] failed in her duty to ensure that the nursing and associated assessments and long term care plan were completed fully and comprehensively once he became a long term private resident. [Ms D] also failed in her duty to ensure that wound assessments and wound care plans were developed for the right hand from 17 September to 11 November and for the leg wounds during the period of time from 3 January to 23 April 2007. This failure of duty was at both Governance level and personal Registered Nurse level and would be viewed with moderate disapproval.

[Ms D's] failure to ensure that documentation was completed during every phase of [Mr A's] tenure at [the Home] has led to inconsistencies in retrospective accounts of events as described in response to the Health and Disability investigation. It appears that retrospective documentation was made in resident progress notes as mentioned during the Transcript of Interview of [Ms D]. I have made comment about this retrospective documentation of care and [Ms D's] associated responsibility as a separate issue under question 16.

5. What standards are applicable to this case, and were these standards followed.
The standards that apply in this case are: Health Practitioners Competence Assurance Act 2003, Health and Disability Standards 2001, Nursing Council of New Zealand Code of Conduct for Nurses and Midwives 2001 and Nursing Council's Competencies for Registered Nurses. [The] District Health Board's Respite Care Contract and Aged Related Residential Care Contract are relevant standards for subsidised residents and should be applied ethically to private residents.

None of these standards were followed and reference is made to this under specific questions.

If not commented in 3, above, please provide the following advice, giving reasons for your view:

6. Please comment on the standard of documentation maintained by [the Home] from 17 September to 11 November 2006.
[The Home] has not provided any nursing or medical related documentation for the period from 17 September to 11 November 2006; this includes: nursing assessment, falls assessment, skin assessment, nursing care plan, wound assessment, wound care plan, progress notes, GP notes, medication chart or list and medication administration chart. One Incident/Accident Report Form/Non Conformance form was partially completed on 8/11/07; areas not completed are: '*Designation; Contributing Factors; Designation; Family member notified, Date, Time, Notified by, Designation; Was this accident preventable? Yes/No, If Yes, what has been done to prevent a re-occurrence*'. An Incident/Accident Report Form/Non

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Conformance form was not completed for the re injury of the right hand on 11 November 2006.

[The Home] has not provided a list of medication that [Mr A] was prescribed by his GP; this list should preferably be written by [Mr A's] GP or alternatively his Pharmacist and have been obtained at the commencement of his tenure at [the Home]. [The Home] Caregivers should have used this list of medication to administer [Mr A's] medication from. They should have recorded the medication given, and signed for, on a medication administration chart. If [Mr A] was self administering his medication, [the Home] should keep the list of medication in his file and document on the Short Term Care Plan that he was self medicating.

[The Home] has provided the following policies: '*Wound Management Procedures, Date: 14th August 1999; Aseptic Wound Care dressing Procedure, Date: 14th August 1999; Wound Care Products, Date: 14th August 1999; Client Progress Notes, Date Updated: 16-Sep-07; Accidents and Incidents, Date Updated 29-Nov-07; Accident Investigation Police, Date Updated: 29-Nov-07; Incident/Accident Report Form/Non Conformance, date Updated: 29-Nov-07; First Aid, Date Updated: 29-Nov-07; Bandages, Date Updated; 29-Nov-07; Policy on Resident Falls, Date Updated: 29-Nov-07; Management of Falls, Date Updated: 29-Nov-07; Falls Risk Factors Score Care, Date Updated: 29-Nov-07; Control of Non-Conforming Product, Date Updated: 29-Nov-07; Control of Non-Conforming, Date Updated: 29-Nov-07'*. The Wound Management procedures, although they hadn't been reviewed for several years, were clearly available for the staff to refer to and follow. The rest of the policies supplied were reviewed in September and November 2007 which was well after [Mr A] ceased receiving services at [the Home]; this raises the question as to whether there were any previous versions of these policies for the staff to refer to or if any previous versions of policies covered the required standard of care and documentation. Please refer to Question Sixteen for further comment.

Under Question Three, I commented on the requirements under the DHB's Respite Care Contract 2005 for subsidised residents and that I believed [the Home] should have ensured [Mr A] received at least the same level of care which included documentation. Also noted under Question Three, the individual Registered Nurses and Nurse Manager were required to maintain nursing related documentation and Question Four regarding the Nurse Manager's responsibilities for documentation of care.

My Opinion

In my opinion, with documentation during the period from 17 September to 11 November 2006 being almost non existent, the standard of documentation was substandard, extremely poor and this would be viewed with severe disapproval.

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7. Please comment on the standard of wound care provided to [Mr A] between 17 September and 11 November 2006.

On 8 November [Mr A] was found in the bathroom bleeding from his wounds. As stated in Question One, [the Home] partially completed an Incident/Accident Report Form/Non Conformance form which did not describe the wounds and where exactly they were located. [The Home] did not complete a wound assessment or care plan or alternatively a short term care plan which can be used for short term requirements such as skin tears.

On the night of 11 November [Mr A] re injured his right hand, following which he deteriorated and was admitted to [public] hospital on 12 November 2006 with cellulitis of the right hand and mid forearm, as stated in Question One.

There are no progress notes documented for the period from 17 September to 11 November 2006 to describe care given to [Mr A] at the time of the above events or any care between the two events. Summaries of the events were written by [the Home] and sent to the Health and Disability Commissioner. As stated in Question One, the skin tears sustained on 8 November were cleansed and dressed with paraffin gauze.

[Ms D's] letter to Rae Lamb, Deputy Commissioner, dated 9 September 2007 (page 00077) states: *'On Saturday 16 December [Mr A] sustained a skin tear to his right hand by banging his hand on the bedroom wall… The dressing was renewed daily due to ooze. On the 17 December the wound had not changed. On the 18 December it was noted that his right hand was swollen and that the wound looked infected. He appeared to be in pain so we immediately contacted the daughter, [Ms C], who took her father for medical attention as he was still under his own GP care'*.

There is no evidence that the wounds on [Mr A's] arm/hand were reviewed by [the Home] staff between 8 November and 11 November 2006. As stated above, [Ms D] refers to daily dressings occurring on [Mr A's] right hand skin tear; the date of the event should be November as discussed in Question Sixteen. I find it difficult to believe that [Mr A's] hand did not show signs of infection prior to the 11th or 12th of November and that if the Registered Nurse, Ms E, had redressed it on the Monday (day before admission to hospital), there would have been evidence of infection at that time. My view is supported by the ambulance report referring to the wrist being swollen as well which also indicates that the hand would definitely have shown signs of infection on the Monday review, if not before. The [DHB] clinical notes described the right hand as being swollen ++ and hard with cellulitis of the mid forearm which supports my view.

Normally a skin tear would not require dressing each day and would be redressed as per the instructions for the type of dressing used unless: the resident had complained of pain, there was evidence of redness on the skin around the dressing, a further injury occurred to the area, there was a history of skin infections such as

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[Mr A's] history of MRSA, or when the resident was unwell with or without a raised temperature, where you would want to check the wound for infection. The caregivers should alert the Registered Nurse immediately if they noticed any redness surrounding the dressing or if the dressing had oozed through the base dressing or any complaints of pain at the site.

The dressing of paraffin gauze is inappropriate for a skin tear; I would have expected the dressing to be assessed for the degree of tissue loss and exudate/bleeding and the appropriate dressing to be put in place. Such dressings for a wound which was bleeding heavily would be as described in the Smith & Nephew New Zealand Wound Care Catalogue January 2005 pages 24 & 25 which state: *'Wound Type: Pre-tibial lacerations (Skin Tears)… Level of Exudate (oozing): Dependent on degree of tissue loss; Purpose of Dressing and Dressing Options: Facilitate control of bleeding — Calcium Alginate, Realign skin flap — skin closure strips, Prevents infection Moist wound healing Assist with pain control Protection/Padding — Minor flaps — Waterproof/bacteria proof island dressing Intermediate flaps — Hydrocolloid Deeper wound — Hydrocellular foam'*. For the outer layer: If the wound was dressed with Calcium Alginate it can be covered with a film, hydrocolloid or hydrocellular foam — depending on exudate level; for a Hydrocolloid then it is self adhesive; for a Hydrocellular foam it may be self adhesive or alternatively would be covered with a clear film Opsite or Tegaderm. Alternatively, if the wound was oozing but not moderately or heavily, than a Post Op Opsite which has an absorbent pad in it may be used. Hydrocolloids are redressed: *(Smith & Nephew NZ Wound Care Catalogue, page 49) 'dressings should be changed once the exudate causes the dressing to become transparent. Please refer to guide below*' and Hydrocellular foams are redressed as per the Smith & Nephew NZ Wound Care Catalogue, page 44: *'Change when exudate stain is within 1cm of the outside edge'*.

A Registered Nurse should be fully competent to dress simple wounds such as skin tears and the Wound Care Catalogue mentioned above is readily available from the Smith & Nephew reps and is an excellent resource wound care book for all Registered Nurses as it shows wounds in different stages, how to assess wounds, write up wound care plans and decide on appropriate dressings for the wounds. This catalogue can be used with other companies' wound products as they are classified under headings such as Hydrocellular foams and Hydrocolloids, etc. Should the Registered Nurse require advice on a wound, then usually they are able to speak with a Wound Specialist Nurse from the DHB or Community Based Services.

It was stated on the incident form dated 8/11/06, as previously discussed in Question One: '*Another staff member went over to do the dressings'*. On 12/11/07 [Ms D] was in attendance for [Mr A's] re injury of his right hand which occurred on the night of 11/11/07; she did not assess or dress the wound herself, a caregiver, [Ms G] did. In the transcript of the interview with [HDC Investigator] (page 00014) it states: '[HDC Investigator]*: So when you put in a letter, "he was*

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assessed and a dressing was applied by one of the registered nurses". [Ms D] that was wrong? You meant to say someone else; [Ms D]: Yeah. I over saw it and thought this, this and this. But [Ms G] who has been working in rest homes for probably like 15 or 16 years, very experience lady, but that's [Ms G's] duty to do it'. Although senior Caregivers do simple dressings on residents and particularly when a Registered Nurse is not on duty, in [Mr A's] case I would have expected [Ms D], Nurse Manager or another Registered Nurse to have done the initial assessment and wound dressing on 8/11/06 given his history of MRSA, the skin tear was bleeding profusely and that it clearly required a Registered Nurse assessment of the wound and wound products to use. In relation to the re injury on the night of 11/11/07, I would definitely have expected [Ms D] to have assessed and dressed the wound when she attended [Mr A] on the morning of 12/11/06. Please refer to Question Two for further comment.

My Opinion
In my opinion, [the Home's] standard of wound care was substandard and would be viewed with moderate disapproval.

8. Please comment on the management of [Mr A's] care during, and following, his admission to hospital on 1 October 2006.
[Mr A] was admitted to hospital on 1 October 2006 following haematuria from Saturday (30 September 2006) and urinary retention with severe pain overnight. The urinary retention spontaneously resolved, by voiding a blood clot at 0600, whilst at [the Home], prior to the hospital admission.

The hospital notes demonstrate good care was provided to [Mr A] and his care was managed well. He was referred to the Urology Outpatient's Clinic (page 00179), his urine was dipsticked and a specimen was sent for histology (page 00185); this was negative for a bladder infection (page 00175). [Mr A] passed urine freely in ECC and was discharged back to [the Home] on 1 October 2006 at 14.59 as per the Public hospital Discharge & Coding Summary (page 00175).

On return to [the Home], there are no progress notes or care plan to establish what care [Mr A] was given in relation to his urinary problems or any needs he had generally or how his care was managed.

[The Home] has not provided any documentation written during this period of time. Information was sent to the Health and Disability Commissioner which outlined the care given to [Mr A] for his right hand injury and re injury; this has been discussed under Questions One, Seven and Sixteen. From the information provided, the inconsistencies in describing the events, it appears to me that [Mr A's] care was not well managed from his admission to hospital on 1 October 2006 until his admission to hospital on 11 November 2006.

[Mr A] was readmitted to [the Home] on 3 January 2007. The Gerontology Nursing Assessment Form, completed on 9/2/07, (page 00043) does not describe

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any issue with haematuria and history of urinary retention. The Elimination Assessment Domain (page 00043) only states: *'Bladder: Continent (ticked), Wears pads/ No (circled), Prostatomegaly. (Previous TURP)'*. There is no care plan outlining care for any further event of urinary retention and haematuria. … In view of [Mr A's] recent event of haematuria with urinary retention and severe pain resulting in a hospital admission, this omission on the Gerontology Nursing Assessment Form does not appear to align nor reflect with his medical condition and recent events.

For comment on the management of care given to [Mr A] from his readmission on 3 January to 23 April 2007 in relation to his ADL's and right leg, please refer to Questions Eleven, Thirteen and Fourteen.

My Opinion
In my opinion, [the Home] did not adequately manage [Mr A's] care following his admission to hospital on 1 October 2006 and that this lack of management was substandard and would be viewed with moderate disapproval.

9. Please comment on the responsibility of [the Home] in relation to any requirement [Mr A] had for urgent medical review in the period 17 September to 11 November 2006.
As previously discussed in Question One, [Mr A] was admitted to hospital on 1 October 2006. He began passing blood clots on Saturday afternoon (30 September) experienced urinary retention with severe pain during the night which resolved spontaneously and was admitted to hospital on the morning of 1 October. In my opinion, it would have been advisable for [the Home] to have contacted [Mr A's] GP or his on call GP on the afternoon of the Saturday, to seek advice for management of his haematuria or a medical review. During the night when [Mr A] experienced the urinary retention with severe pain, [the Home] should have contacted his GP/on call GP for urgent medical review as previously discussed.

[Mr A] was admitted to hospital on 11 November 2006 following his right hand injury on 8 November and re injury on 11 November 2006, as discussed in Questions One and Seven. In my opinion, [Mr A] should have received urgent medical review between 8 November and 11 November 2006 when the hand would clearly have become swollen, red and oozing. It is difficult to determine the exact day the urgent medical review should have occurred due to lack of documentation, however I believe that the wound would have been showing signs of infection by the 9th or 10th November and urgent medical review would have been appropriate then. As [Ms D] has stated that daily dressings were done on [Mr A's] hand (refer to Question Seven), it would have been clearly obvious when the wound was showing signs of infection.

The DHB's Respite Care Contract 2005 for Subsidised Residents states: *'3.1 c: Your service will: 2. Initiate any early treatment of acute illnesses or exacerbations of chronic health problems and reduce the need for increasing*

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ongoing support services by referring the client onto … general practitioner; 7.4 Client Charges: You will not charge clients … Exclusions: … costs of medical services'. Although the contract is for Subsidised Residents and does not cover privately funded respite care residents, [the Home] is ethically obliged to at least provide the same level of care for privately funded respite care residents.

I note that [Ms D] stated in her letter dated 9 September 2007 to Rae Lamb, Deputy Commissioner (page 00078): *'8. Short stay residents are under the care of their own GP and it is therefore the responsibility of their family to take them to appointments and provide medication and medical notes'*. [Ms F] outlined 'the calling doctors in an emergency procedure' as stated in the Complaint Action (page 000161): *'In relation to calling doctors in an emergency, stated that [Ms D] told her and [Ms E] that they should call her before calling a doctor or an ambulance'*.

My Opinion
In my opinion, [the Home] should have ensured that [Mr A] received urgent medical review during the night before admission to hospital on 1 October 2006 and either on 9th or 10th November 2006 when the right hand showed signs of infection; this clearly did not occur.

In particular, [Ms D] had overall responsibility to ensure that [Mr A] received urgent medical review. Her letter stating that it was the responsibility of the family to take them to their own GP is relevant to planned appointments but not for urgent medical review. [Ms D's] apparent instruction to the Registered Nurses that they were not allowed to call a doctor before calling her implies that urgent medical review would be delayed or not approved by [Ms D]; this is unacceptable.

In my opinion, [the Home], and [Ms D], failed to ensure that [Mr A] received urgent medical review; this would be viewed with moderate disapproval.

10. Please comment on the standard of communication with [Mr A's] family.
There are no progress notes from [Mr A's] admission to [the Home] on 17 September to 11 November when he was admitted to Public hospital. On his readmission to [the Home] 3 January 2007, there are sporadic progress notes until his admission to [public] hospital on 23 April 2007, with no progress notes between 26 February and 2 April 2007. The following communication with the family is documented in the progress notes as follows: *'7/1/07 Daughter [Ms B] in hospital unable to locate other daughter [Ms C] as apparently [Mr A] says has gone on holiday. Informed the hospital on covering letter how I hadn't been able to contact family. 22/4/07 12.00 [Mr A] had a fall found by cleaner. Had sustained a small skin tear on R arm. No shortening or rotation noted … [Ms D] informed & daughter [Ms C]; 23/4/07 Reported [Mr A] was c/o feeling unwell … Dressing reviewed. Daughter [Ms B] informed result from swab taken on Thursday showed R) upper thigh infected +'*.

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There are three Incident/Accident Report Form/Non Conformance forms documented for [Mr A], dated: 8/11/06, 16/4/07 and 22/4/07. There is no documentation on the 8/11/06 Incident Form stating that the family were contacted. The other two Incident Forms state family were contacted: *'Date of Incident: 16/4/07, Family member notified: Daughter [Ms B], Date 16/4/07, Time 17.00; Date of Incident: 22/04/07, Family member notified: ? name (partner), Date 22/04/07, Fell off bed after having a nap and sustained a small skin tear … Family member notified ? Name of person (partner) Date 22/4/07 Time ? 1605; Notified by [Ms F]'*.

[Ms E's] typed version of events for [Mr A] in April (page 00164) states: *'On the 23rd April 2007 my next duty day I was informed [Mr A] had a fall in his room the previous day (Sunday) sustaining a skin tear to his right arm…It was reported to me the caregivers had difficulty getting [Mr A] out of bed for breakfast, he appeared to be unwell … Within half an hour of me leaving [Mr A's] room the caregiver asked to re-examine [Mr A] as he had become 'vague' … I asked the senior caregiver to stay with [Mr A] while I went to phone Medlab for the swab results … I informed [Ms D] and phoned [Ms B] ([Mr A's] daughter) to tell her [Mr A] had an infection in his leg … and so I was arranging for him to be transferred to [public] hospital for assessment. Unfortunately [Ms B] was not at home as she was moving so I left the message with her partner'*. Ms B's letter dated 10 July 2007 to Mr R. Patterson, Health and Disability Commissioner (page 0002) states: *'On the 23.4.07 dad was admitted again to [public] hospital … I was rung by the Senior Nurse and part owner of the [the Home] to say my Dad wasn't well. I asked what the problem was and she told me it was his leg … Someone in the background where she was ringing from said, 'I took a swab of those wounds last Thursday', this was now Monday at 1330hrs, I then asked what the results were, 'Oh', and she said 'we should look up the results … She then said 'Oh they are infected'*. The provisional swab result (page 00155) states: *'23 Apr 07 10 49 Request Enquiry Report … [Mr A] … Collected 19 Apr 07 10.0 ... Clinical details: R leg … Moderate numbers of Gram positive cocci seen. Culture Heavy growth of Staphylococcus aureus (MRSA)'*. The final result (page 00153) states: *'[Mr A] … Received: 19 Apr 07 … Reported: 24 Apr 07 … Date and time of collection: 19 Apr 07 10:00hrs … Culture Heavy growth of Staphylococcus aureus (MRSA)*'.

It is clear that the provisional swab result was obtained on 23 April 2007 at 10.40 am as per [Ms E's] documentation that she had phoned for the result then informing [Ms D] and the daughter. However, from the daughter's letter it appears that it was the [Ms D], Nurse Manager and not [Ms E] who phoned the daughter as the daughter described the nurse as *'the Senior Nurse and part owner'*. This shows an inconsistency in the communication at the time of the event as in [Ms E's] account of the event she stated that she had phoned the daughter who was unavailable leaving a message with her partner and the daughter stated that the Senior Nurse and part owner phoned her.

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[Mr A's] daughters admit to the following communication from [the Home] as stated in the Complaint Action page 00170, which described a meeting between [HDC Investigator], [Ms B] and [Ms C]: *'On 1 October, [Ms D] called [Ms C] and informed her that her father had blood in his urine … On 8 November, [Ms C] thinks that she may have been told that her father had knocked his hand on the night causing the injury to the same hand which had been operated on in September … On 11 November 2006, when [Mr A's] condition deteriorated, [Ms E] called [Ms C] and advised her that his condition had deteriorated'*.

[Mr A's] daughters do not admit to the following communication from [the Home] as stated in the Compliant Action page 00170: *'I put to [Ms B] and [Ms C] the statements by [the Home] that he had injured his hand while 'shaking his razor out of his ranch slider' (29 Nov 07 letter); [Ms C] and [Ms B] stated that they had not been told that … ([Ms D] transfer letter of 12 Nov 06). [Ms C] and [Ms B] stated that they had not been told that their father had fallen'*.

[The Home] appears to have contacted the family on 8/11/06, even though they had not documented the communication, and again on 16/4/07 and 22/4/07 according to the Incident/Accident Form/Non Conformable form. The family confirm that they were contacted on 11 November 2006 when [Mr A's] right hand had deteriorated and again on 1 October 2006 regarding the blood clots in [Mr A's] urine; from their statement it does not appear that they were told about the urinary retention and severe pain [Mr A] experienced during the night before. [The Home] had documented in the progress notes on 22/4/07 that they had contacted the daughter, [Ms C], regarding [Mr A's] fall and skin tear; the family do not confirm this communication. The family confirm that [the Home] contacted the daughter [Ms B] on 23/4/07.

[The Home's] Accidents and Incidents Policy supplied had an issue date of 29-Nov-07, which was subsequent to his tenure at [the Home]. This policy (page 00063) states: *'It is RN responsibility to notify family member as soon as possible if the injury is of serious nature, otherwise less serious injury are notified to family member at the discretion of RN during family member's next visit'*. As [the Home] have not provided a policy that was current at the time of [Mr A's] falls, I am unable to determine if staff followed policy in contacting [Mr A's] family after he fell or if in fact they were required to make contact; however, the facility clearly did make contact.

It is unclear as to the quality of the communication and whether family were notified of all relevant details such as falls as the entries by [the Home] do not identify exactly what was said to family. I note that the policy provided, as discussed above, outlines that contact to family is only made for serious injury from falls and for less serious injury, it is the RN's discretion as to when they tell the family about the fall. It is usual policy for facilities to contact family after any falls, however in reality it is not always easy or possible for Registered Nurses to contact families following each fall and they may only contact family for significant falls.

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Ideally the communication regarding falls with/without injury should be clarified with each family on admission and documented in their file.

The DHB's Aged Care Residential Agreement states:

> *'d16.4 Evaluation*
>
> *b. You shall notify the Subsidised Resident's family members, with the Subsidised Resident's consent, as soon as possible, if the Subsidised Resident's condition changes significantly'*. As previously stated, [the Home] is ethically obliged to provide the same level of care as for the Subsidised Resident.

[The Home] did contact [Mr A's] family at the times when he had deteriorated, on the days in which he was admitted to hospital i.e. 11 November 2006, 1 October 2006 and 23 April 2007. [The Home] did not contact [Mr A's] family during the night of 1 October 2006 when [Mr A] was in urinary retention and severe pain. As discussed in Question Sixteen I could not find any documentation in [the] DHB file relating to an admission to hospital on 7/1/07, including the covering letter from the Registered Nurse, [Ms F].

My Opinion
In my opinion, the standard of communication relation to the falls, although minimal, was acceptable. In relation to the communication regarding the urinary retention, severe pain and blood clots, this communication was substandard and would be viewed with mild disapproval.

The standard of communication surrounding the events of 23 April 2007 is mixed. It is clear that the laboratory was contacted for the swab result during the morning; [Ms E] made the statement that she phoned for the result and phoned the daughter. The daughter has made the statement in her letter that she was phoned by the Senior Nurse/Part Owner and only informed of the swab results on further questioning by her. The apparent lack of clarity with the communication would be viewed with slight disapproval. The inconsistency in documentation about the event and communication is discussed further in Question Sixteen.

11. Please comment generally on the standard of care provided to [Mr A] by [the Home] from 3 January to 23 April 2007.
[Mr A] became a privately funded long stay resident on the 3 January 2007; [Mr A] was apparently assessed by NASC on 26 January as stated in the progress notes: *'26/1/07 Visited by [Needs Assessor]'*. The Support Needs Assessment & Service Co-ordination Summary states: *'Date Referral Received 4/1/07, First Contact Date 23/1/07, Date Assessment Completed 26/1/07'*.

Progress notes for [Mr A] commenced on 3/01/07 when transferred from [public] hospital. The admitting notation from the RN states: *'3/01/07 17.00 … Have*

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requested that the ward send a copy of the dressing plan to be renewed every 3 days; … He will require some assistance with ADLs while R hand heals; He is to be on a Soft High Energy Protein Diet with Fortisip in Mane & Cubitan dinner … [Mr A] has been confused and needs prompting to do tasks'. Progress notes were documented in on a daily basis until 7/1/07 and recommenced on 11/1/07 following [Mr A's] return from hospital. The progress notes continued to be documented in until they stopped following an entry on 26/2/07 and recommenced on 2/4/07 until [Mr A's] admission to hospital on 23 April 2007.

A Gerontology Nursing Assessment Form (pages 00042 and 43) was incompletely documented on 9/02/07. The form has a number assessment domains section which have tick boxes under current status and a comment section. Two of the assessment domains were not ticked: Auditory and Speech Language. The assessment domain Motivation states: *'(ticked) willing to do tasks for self'*. There are no comments written for Motivation yet the admission notation in the progress notes on 3/01 07 states: *'needs prompting to do tasks'*. The assessment domain Nutrition and hydration states: *'(ticked) Normal diet … Appetite (ticked) average … Requires Supplement — High Protein'*. The assessment domain Elimination, as discussed in Question Eight, did not document [Mr A's] medical condition of haematuria episodes and recent urinary retention with severe pain that [Mr A] had experienced in his previous admission to [the Home].

A Falls Risk Factors Score Card (page 00033) was completed on 09/02/07 with the total score of 23 which indicates a very high falls risk (10+ is high). A Pressure Risk Assessment (Waterlow) was completed on 10/02/07 which stated: *'Build Weight for Height. Score Below average (scored); … Very high risk … 20; Total score 23; … a total of 10 or more requires preventative measures'*. Preventative measures are stated as following: *'Guidelines for preventative measures for person at risk of developing pressure ulcer. Score 20 + VERY HIGH RISK … Nutrition. Monitor dietary intake. Ensure adequate fluid intake. Refer to dietitian'*.

A patient copy of the Public hospital Discharge & Coding Summary form AT & R Inpatients (page 00137) which describes his admission from 19/12/2006 to 3/1/2007 within the AT & R unit was in [the Home's] medical file which states: *'S/B dietician: Will apply for S99 for fortisip; BUT Healthpac agency closed until 8/1/07, therefore no Healthpac forms will be approved before then. Will need to use complan until S99 approved'*. This information has been translated onto the Gerontology Nursing Assessment Form as it states: *'Nutrition and hydration: Requires Supplement — High Protein'*; and the Nursing Care Plan which states: *'Eating and Drinking: Potential for dehydration & weight loss … 1) Observe input, 2) Provide supplements'*.

A Nursing Care Plan (page 00035) was completed on 10/02/07 which is very simplistic in style. The Nursing Care Plan states: *'Eliminating: No issues of concern'*; the care plan also does not address the recent event of urinary retention

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with severe pain and haematuria nor the risk of further episodes occurring and how to manage them.

The Nursing Care Plan also states: *'Controlling circulation: PVD … 1) Dr review monthly'*. PVD stands for Peripheral Vascular Disease which affects the circulation of the legs. There is no documentation in the Nursing Care Plan about the measures to minimise pressure risk as outlined above on the Waterlow. In view of the PVD and the high pressure risk identified, [Mr A] was at great risk of developing pressure areas/ulcers. I note that a letter from [the Orthopaedic Registrar] dated 24/4/2007 (page 00084) states: *'He has come in with cellulitis of his right calf and an ulcer over the medial knee which has been longstanding … There does remain a non healing ulcer on the superomedial aspect of the knee with a little slough at the base, however there is no evidence that this ulcer is infected'*. In the medical file from [a] Medical Centre (page 00143) which states: *'Right leg below knee amputation … Medical team noticed the bed sore in sacral area, which needed active management to prevent infectious complication'*. There is no documentation in [the Home's] file regarding the long standing ulcer over the medial knee on the Gerontology Nursing Care Assessment or plan to manage it. There is no documentation about the sacral bed sore; however it is not clear whether this was evident on admission to hospital or whether he developed it in hospital.

[Mr A] was assessed by the NASC Assessor on 26/1/07. The Support Needs Assessment & Service Co-ordination Summary (page 2 of the Assessment) states: *'2) Needs walking frame to mobilise; 3) Needs food cut up due to reduced movement in hand…; 5) Needs assistance at times with toileting overnight'*. The Nursing Care Plan does not document any of the needs as stated above in the Support Needs Assessment & Service Co-ordination Summary.

[Mr A] was not medically admitted (page 00152) until 28/1/07, 25 days after his readmission as a long stay resident, then medically reviewed on 15/2/07, 8/3/07, 23/03/07, 29/3/07, 3/4/07. There are no medication chart and medication administration charts in [the Home's] file. As mentioned previously, [the Home] is ethically obliged to ensure that [Mr A] receives at least the same level of care that Subsidised Residents receive under The Aged Care Residential Contract which states:

> *'D 16.7 Support Care and Intervention*
>
> *e. Primary Medical Treatment*
>
> *i You must ensure that:*
>
> *1. each subsidised resident is examined by a General Practitioner within 2 Working days of admission, except where the Subsidised Resident has been examined by a Medical Practitioner not less than 2 Working Days prior to*

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admission, and you have a summary of the Medical Practitioner's examination notes'.

My Opinion

As stated in Question Three, ethically [the Home] was obliged to comply with the DHB's Aged Care Residential Agreement. An initial care plan was not documented on admission on 3 January 2006. The Gerontology Nursing Care Assessment and Nursing Care Plan were completed 37 days following the readmission; the Aged Care Residential Agreement requires them to be completed within 3 weeks of admission.

The Aged Related Residential Care Contract states: *D16.2 c. The assessment utilises information gained from the Subsidised Resident, their nominated representative (where applicable), and information provided by the relevant Needs Assessment and Service Co-ordination Service and/or previous provider of health and personal care services along with observations and examinations carried out at the Facility*; this clearly did not happen.

In my opinion, [Mr A's] Gerontology Nursing Care Assessment was incomplete, sparsely documented in and was substandard. The Nursing Care Plan was substandard. There was no management plan in place to manage the chronic knee ulcer or [Mr A's] potential risk of urinary retention and haematuria. The Nursing Care Plan did not reflect all the needs as assessed by the NASC Assessor. The format of the Nursing Care Plan did not allow the Registered Nurses enough room to document as fully as required or to expand on comments they made.

The progress notes were not completed for the whole period of this tenure and did not adequately state care given to [Mr A]. Refer to Questions Four and Twelve for further comment. Please also refer to Question Thirteen for comments on wound care.

[The Home] did not ensure that [Mr A] was medically admitted within two working days of being readmitted. I note that the [the Home] medical notes do have a patient copy of the [public] hospital Discharge & Coding Summary form AT & R Inpatients (page 00137) which describes his admission from 19/12/2006 to 3/1/2007 within the AT & R unit as discussed above. My assumption is that [the Home] was given the Patient Copy, therefore under these circumstances; it was acceptable that [Mr A] was not medically admitted until 28/1/07. However it is unacceptable that [the Home] did not have a medication chart for [Mr A], nor did they have a medication administration record chart. There is no documentation to say whether [Mr A] was assessed as able to self administer following his septic shock and skin grafts and he would probably have had difficulty managing a medication blister pack such as a Medico Pak thus requiring assistance.

In my opinion, overall the standard of care given to [Mr A] by [the Home] was substandard and would be viewed with moderate disapproval.

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In my opinion, the Registered Nurses and Nurse Manager failed in their duty to give an adequate standard of care to [Mr A] and this would be viewed with moderate disapproval.

If not commented in 9, above, please provide the following advice, giving reasons for your view:

12. Please comment on the standard of documentation maintained by [the Home] from 3 January to 23 April 2007.
The progress notes commenced on 3 January 2007 with the admission notation describing briefly what had occurred medically during the admission to hospital and [Mr A's] requirements such as his '*[Mr A] is mobilising with a frame with supervision. He requires some assistance with ADLs while R hand heals'*. As above in Question Eleven, the progress notes were documented in on a daily basis until 7/1/07 and recommenced on 11/1/07 following [Mr A's] return from hospital. The progress notes continued to be documented in until they stopped following an entry on 26/2/07 and recommenced on 2/4/07 until [Mr A's] admission to hospital on 23 April 2007.

[The Home] provided a separate progress note (page 00150) which documented the skin tears that occurred on 16/4/07; it states: '*16/4/07 FOOTNOTE. Additional notes added as not back at work on Monday and did not document in progress notes only communication book for RN. Unable to document on Tues as notes for 17/4/07 had been written. ([Ms D] informed)'*. This footnote implies that retrospective notes would have been written within the progress notes. In the Transcript of Interview of [Ms D], the question of retrospective notes was addressed as stated: '[HDC Investigator]*: Because you've supplied that to say this is what was written after. [Ms D]: Because there was no gaps left. [Ms E]: Yeah. [Ms D]: And these girls have carried on writing it out without the RN writing their bit in.* [HDC Investigator]*: So they're retrospective notes is what you're saying. [Ms E]: … [Ms F] was literally going out … so instead of writing it at the time, she wrote it when she came back on duty, hence I carried on, I didn't leave her no space … [Ms E]: And again I wrote my bit. We just wrote it afterwards, because there was no spaces left due to our progress notes. Because there were no spaces left we wrote it like afterwards. So that's why they're included like that'*.

In Question Eleven I have discussed the documentation on the Gerontology Nursing Assessment Form, the Falls Risk Factors Score Card, the Pressure Risk Assessment (Waterlow) and the Nursing Care Plan. As discussed above, the standard of documentation on the Gerontology Nursing Assessment Form and the Nursing Care Plan was substandard. The documentation on the Falls Risk Factors Score Card and the Pressure Risk Assessment (Waterlow) was acceptable.

In Question Thirteen, I discuss the documentation in relation to wound care; please refer to this question for further comment.

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[The Home] has not provided a medication chart and medication administration chart. The medication chart should have been written up by the admitting doctor and this should have been done on admission unless [the Home] had a copy of the medication scripts from the hospital which they used to administer the medication from. From the needs assessed as discussed in Question Eleven and [Mr A's] reduced memory (refer to page 2 of NASC assessment *'Memory/behaviour reduced'*), [Mr A] did not appear to be capable of self administering his medication safely and therefore I would have expected [the Home] to have administered it for him.

[The Home] has provided two Accident/incident Report Form/Non Conformance for[Ms F]or 16/4/07 and 22/4/07. The 16/4/07 form (page 00132) is partially completed. The following sections have not been completed: *'Notified by: (Full Name of Staff) Designation; Was this incident preventable? Yes/No; If Yes, what has been done to prevent a re-occurrence'*. The 22/4/07 form (page 00133) has the same sections uncompleted.

Under Question Three I commented on the requirements under the DHB Aged Care Residential Agreement for Subsidised Residents and that I believed [the Home] should have ensured [Mr A] received at least the same level of care which included documentation as stated in Clause D8 Clinical Record System. Also noted under question Three, the individual Registered Nurses and Nurse Manager were required to maintain nursing related documentation and Question Four regarding the Nurse Manager's responsibilities for documentation of care.

My Opinion
In my opinion, the standard of documentation during the period from 3 January to 23 April 2007 was substandard and would be viewed with moderate disapproval.

In relation to the retrospective documentation of care, it is unacceptable to leave gaps in progress notes for the Registered Nurses to document an event later. It is acceptable for the Registered Nurse to document a file note for an event that occurred prior to the time of the progress note entry; however it must have the date and time of entry clearly stated, be clearly identified as a file note and reference to the time and date of the event when it actually occurred. In my opinion, I believe that retrospective documentation of care in gaps which have been left for this to occur is unacceptable and would be viewed with severe disapproval.

13. Please comment on the standard of wound care provided to [Mr A] between 3 January to 23 April 2007.
[Mr A] was transferred back to [the Home] from hospital on 3 January 2007. There is no nursing transfer letter from the hospital within [the Home's] file. At the time of his readmission, the progress notes state: *'[Mr A] has a skin graft to his Rt hand. Donor site from Rt leg. He has a small ulcer on his 2nd toe left foot. Have requested that the ward send a copy of the dressing plan to be renewed every 3 days as daughter in hospital also'*. The [DHB] Wound Assessment & Treatment

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Plan states: *'3/1/07 Frequency of dressing change 3 days, Cleaning solution N/Saline, Primary dressing L) wound on top of hand — Bactri (? Bactriban) small wound on ring finger side of hand — intrasite, Secondary dressing conformable, Securing Melonlin soft ban + crepe … Evaluation date 6/1/07'*. There is no evidence of any wound assessment or care plan by [the Home] Registered Nurses for [Mr A's] hand following his readmission on 3 January 2007 until a Wound Treatment Plan was written up on 13/1/07. The Wound Treatment Plan was similar to the [DHB] Wound Assessment & Treatment Plan. There is no evidence of any assessment or Wound Treatment Plan for the small ulcer on [Mr A's] 2nd toe left foot.

[The Home] reviewed [Mr A's] hand, as directed by the hospital, on the 6/1/07 as stated in the progress notes: *'6/1/07 12.00 Hand redressed and will need reviewing on Sunday again. 7/1/07 12.00 At approx 11.30 was called to assess [Mr A] who was at that time having rigors. He c/o of intense pain in his Rt hand. BP & Pulse stable T 38.3 ... Pt approx 13.00 c/o of pain in his R ear and top of neck region. C/o no pain in chest or nil pain radiating. BP … had dropped to 108/48 … Ambulance rang again to inform them of blood pressure dropping'*.

There is no documentation of the status of the hand wound on 6 January 2007 at the time it was redressed. [Ms F], RN, has typed a notation regarding the hand wound on page 00162 which states: *'On 07/01/07 at approximately 11.30 hrs whilst attending to two patients requiring hospital admission I was asked by a caregiver to review [Mr A] who was complaining of feeling cold and having pain in his right hand … Approximately five minutes later … I went to see [Mr A] who was complaining of bad pain in his right hand and was shivering. I took his recordings immediately — Temp 38.3 BP 120/77 and Pulse 8 8 … As I had to return to the residents still to be transferred to hospital I asked a caregiver to stay with [Mr A]. When I went back to see him he appeared to have improved and he said his hand was slightly better. At approximately 13.00 hrs [Mr A] complained of pain in his right ear and the top of his neck. At this time his Temp 38 Pulse 83 and his BP had dropped to 108/48. At this stage I gave him 1 gram of Panadol and rang the ambulance to request his transfer to hospital'*.

The documentation in the progress notes and [Ms F's] letter regarding the admission for the right hand on 7/01/07 appears to be inconsistent with events; there is no documentation in the [DHB] file of an admission on the 7/01/07 regarding [Mr A's] hand and his raised temperature. Please refer to Question Sixteen for further comment.

[The Home's] progress notes states: *'13/1/07 12.00 Dressing renewed yesterday on hand. Fingers remain swollen; 14/1/07 12.00. Fingers markedly more swollen today. Dressing removed; 16/1/07 16.00 Dressing redone at outpatients clinic appointment; 18/1/07 19.00 Dressing renewed on hand and toe. No Comfeel available for one finger so intrasite and Combine (? word) commenced*. [the Home] commenced a Wound Treatment Plan for the hand on 13/1/07 and reviewed

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the wounds on 15/1/07, 17/1/07 and 19/1/07. These entries state: *'13/1/07 … Intrasite gel to sm sloughy area on finger & hand; 15/1/07, 17/1/07 and 19/1/07 Intrasite to sloughy area + adaptic'*. The Wound Treatment Plan does not describe the product to be used to secure the wound dressings. The progress notes on 18/1/07 indicate that Comfeel was meant to be used as the dressing which is different from the products described on the Wound Treatment Plan. There is an inconsistency between the documentation within the progress notes and the Wound Treatment Plan on the days the dressings were done and the type of product to be used.

[Mr A's] hand wound was reviewed by his new GP on 25/1/07 as stated: *'25/1/07 11.00 S/B Dr […] — new resident admission … wound on R) hand reviewed to continue dressing'*. The wound dressing was altered on 26/1/07 apparently on the daughter's instructions as stated in the progress notes: *'26/1/07 11/00 Visited by daughter who requested [Mr A's] hand to be left with no bandage during the day to have 2–3 drops bio oil put on and to have tubigrip at night for protection only'*. The Wound Treatment plan was also altered as per the daughter's apparent wound dressing changes; this is the last documentation on a Wound Treatment form that [the Home] has provided for [Mr A]. [Mr A's] hand was reviewed again on a routine visit by Doctor […] (? Spelling) as stated in the progress notes: *'15/2/07 12.00 Seen by Dr […]. Hand reviewed and no new orders'*. The Doctor's notes states: *'15/2/07 Routine … R hand satis'*.

[The Home's] progress notes stop on 26/2/07 and recommence on 2/4/07. The next documentation of the hand wound is in the progress notes on 7/4/07 and states: *'7/4/07 Old wound checked. Skin intact'*.

[Mr A] sustained skin tears on his right leg on 16 or 17 April 2007 whilst in the company of his daughter on an outing. There are inconsistencies in the accounts from the daughter concerned and [the Home] as to whether it was a heater or walker that caused the skin tears, how many skin tears occurred, the locality of the three skin tears and what date the skin tears actually occurred. The daughter stated: *'I had taken him out ... Sunday … as I was putting his walker together in the car park it slipped through my hands and caused three skin tears down Dad's right knee and ankle'*. Sunday in April 2007 is actually the 15th April. The Incident/Accident Report Form/Non Conformable form states: '*date of incident 16/4/07*'. [Ms F], Registered Nurse admitted to getting the incorrect date on the incident form as described in the Complaint Action on page 00160: *'2–3 days later, [Ms F] made a special visit to [the Home] to make a record in the progress notes and also to complete the incident form. Agreed that she had put the incorrect date on the form'*. [The Home] redressed the upper leg dressing on his return to the rest home: *'Upper wound redressed'*; there was no description of the dressing used.

Handwritten notes for the period of time from 16/4/07 have been provided in relation to [Mr A's] wounds; these are pages 00168 and 00169. They state: *'16/4/07 At approx 17.00 daughter informed nurse on duty that whilst on an*

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outing she accidentally dropped a heater on [Mr A's] right leg. This caused two skin tears one on his upper leg and one lower; 17/4/07 Reviews [Mr A's] R) leg wounds — the upper wound appeared to be on his inner thigh approx 3cm … 2 x lower leg wounds appeared to be superficial grazes'. [The Home's] progress notes states: *17/4/07 Reported [Mr A] has skin tear to R) thigh & lower R) leg due to his daughter accidentally dropping a heater on his leg … Dressing renewed appears to be leaking (? Word)*. The daughter dressed the skin tears at the time of the occurrence using wound dressings from her car's first aid kit.

[The Home's] progress notes states: *'17/4/07 13.00 Reported [Mr A] has skin tear to R) thigh & lower R) leg due to his daughter accidentally dropping a heater on his leg off her car in the weekend. Dressing renewed appears to be healing; 21/4/07 12.00 Dressing renewed by [Ms G]; 22/4/07 12.00 Dressings renewed. Top leg sloughy & slightly pink around periphery. For a swab tomorrow … 23/4/07 11.00 Reported [Mr A] was c/o feeling unwell responding to speech but appears vague … Temp 38.25 Dressing'*. No further progress notes have been supplied by [the Home]; [Mr A] was admitted to hospital on this day.

[The Home] provided a separate progress note (page 00150) which documented the skin tears that occurred on 16/4/07; it states: *'16/4/07 … 17.00 Daughter informed me that [Mr A] had sustained two skin tears re his R leg both upper and lower after dropping a heater on his leg accidentally whilst out … the lower dressing could be left until tomorrow but the upper wound to be redressed which I did … [Mr A's] observations were within normal limits … Staff informed to observe overnight. Message left in communication book for Nurse to check in morning'*.

[Ms F] clarified the dates of the event in the Complaint Action (page 00160) as stated: *'Was present when on 15 April [Mr A's] daughter told her that there had been an accident which caused the skin tears on his legs … Agreed that she had put the incorrect date on the form, stating the injury occurred on 16th (when it happened on 15th) and that she did not sign the form on 16th, as stated, but when she completed the form'*.

[The Home] has documented the following reviews of the right leg wounds in a handwritten note (page 00168), written apparently by one of the Registered Nurses: *'17/4/07 Reviews [Mr A's] R) leg wounds — the upper wound appeared to be on his inner thigh approx 3cm no slough noted, appeared clean. No redness around surrounding area no c/o pain. Cleaned with N. saline redressed using non adhesive gauze & secured with tegaderm. 2 x lower leg wounds appeared to be superficial grazes. Cleaned with n. saline & Opsite dressing applied; 19/4/07 Reviewed [Mr A's] leg wounds. Upper thigh appeared sloughy & redness on surrounding area — swab taken. Redressed with paraffin gauze & gauze. 2 x lower wounds appeared clean no redness noted. Cleaned with n. saline redressed with paraffin gauze & gauze. No c/o pain. 23/4/07 … @ 8.30 am to be told [Mr A] was c/o feeling unwell. Noted to have slurred speech … I found [Mr A] to be vague but*

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responsive to speech … reported findings to [Ms D]. At 9.30 am … asked me to reassess [Mr A] as he was vague & unable to stand … [Mr A] had a temp 38.25 … Dressing removed from wounds & both upper/lower appeared red & sloughy … swab result which showed MRSA & Staphylococcus. I informed [Ms D] & phoned [Mr A's] daughter [Ms B] … I spoke to [Ms B's] partner as she was not [available] due to them moving house … decided to transfer [Mr A] … [Mr A's] GP was also notified'.

[Ms E] has typed a report of the event (page 00164) which states: *'On the 17th April 2007 I arrived on duty and was informed at handover [Mr A] had 2 skin tear wounds, one on his upper right thigh and one on his lower right leg … I assessed [Mr A's] wounds and redressed them. The upper thigh skin tear was approx 3cm in diameter it appeared clean, no sign of infection and [Mr A] didn't complain of the wound being painful. I cleaned it with normal saline, applied a non-adhesive dressing and secured the dressing with tegerderm. The lower right leg had one skin tear approx 2cm in diameter and a small superficial graze area. The wounds both looked clean with no signs of infection, [Mr A] also said they were not painful. I cleaned the skin tear with normal saline and applied an Opsite dressing. The small graze area I cleaned but did not apply a dressing as it appeared to be dry and clean … On the 19th April 2007 my next duty day I reviewed [Mr A's] skin tear wounds. The upper thigh wound appeared sloughy with slight redness on the surrounding skin, I took a swab and redressed the wound using normal saline to clean it, and I applied Foban (an antiseptic cream) paraffin gauze and a gauze dressing. The lower leg skin tear appeared clean, no sign of infection, the graze appeared to have broken down so I applied a dressing to both wounds, and I cleaned them with normal saline, and applied a paraffin gauze dressing. [Mr A] did not complain of any pain … On the 23rd April 2007 my next duty day I was informed [Mr A] had a fall in his room the previous day (Sunday) sustaining a skin tear to his right arm, no other injury noted … Within half an hour of me leaving [Mr A's] room the caregiver asked to re-examine [Mr A] as he had become 'vague'. Upon assessment [Mr A] appeared to have become disoriented to time and place, incontinent of urine. His temperature was 38.25 centigrade. I removed the dressings from both upper and lower wounds; they appeared sloughy with redness around the peripheral skin area … I went to phone Medlab for the swab results. The swab results showed MRSA and Staphylococcus infection … I was arranging for him to be transferred to [public] hospital for assessment'.*

[Ms F] has provided the following report on the leg wound (page 00163) which states: '*When I returned to work on the 21/04/07 after leave [Mr A's] dressings had already been done by a caregiver. I checked them and there was nothing unusual to report. On the 22/04/07 — The top wound on the leg appeared sloughy and slightly pink around the periphery. I redressed it and recommended that a swab be taken the next day. (Monday)'*. [Ms F] does not describe as to whether she took the dressing down to check the wound on the 21 April 2007 or whether she just checked the area around the dressing.

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[The Home] have not provided any wound assessment or wound care plans for the right leg skin tears by [the Home] Registered Nurses during the period 15 April to 23 April 2007.

My Opinion
The wound care given for the right hand from 13/1/07 to 25/1/07 is adequate and acceptable despite the lack of wound assessment by [the Home] Registered Nurses. I note that they requested [the] DHB to send their wound management plan, which it appears that [the Home] followed using similar products. GP reviews of the hand did not occur until [Mr A] was reviewed by a GP on 28/1/07; these indicate that the hand was healing well.

In my opinion, the lack of wound assessment, inconsistencies between the progress notes and Wound Treatment Plan for the wound dressings, lack of ongoing documentation about the hand wound in the progress notes and Wound Treatment Plan demonstrate inadequate documentation and care and would be met with moderate disapproval.

In my opinion, the apparent inconsistencies documented in the notation by [Ms F] and the progress notes re the right hand and [Mr A's] unwellness event apparently resulting in an admission to hospital on 7/1/07 raises serious concern; please refer to Question Sixteen for further comment.

There are no documented short term care plans or wound care plans for the right leg skin tears. The progress notes describe that the skin tear on the upper leg was sloughy and the dressing used: *'19/4/07 Upper thigh appeared sloughy & redness on surrounding area — swab taken redressed with paraffin gauze & gauze'*. It was appropriate that a swab was taken at this stage, but the type of dressing used was inappropriate for a sloughy wound which had, in addition, surrounding area of redness.

In my opinion, the sloughy wound on 19/4/07 should have been dressed with a primary dressing that was appropriate for sloughy wounds and also to address the issue of a probable skin infection occurring. The New Zealand Wound Care Catalogue describes such primary dressings on page 25 which include: *'Idosorb, Acticoat, Silvazine'*. Many rest homes would not necessarily have Idosorb and Acticoat in their wound care cupboard, due to the infrequent use and expense of these products, but they can be readily obtained from companies supplying wound care products. However, Silvazine is used commonly and is not expensive and should be available to rest home staff to use as required. Betidine solution is also used commonly and would also have been appropriate to use whilst acquiring any specialist dressings required. I note that [Ms E] applied Foban to the upper thigh wound on 19 April 2007, which she used as an antiseptic cream.

The Registered Nurse, from the handwritten note and typed report, redressed the skin tears and took a swab of the sloughy thigh skin tear on 19/1/07. The dressings

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were then redressed by a Caregiver on 21/1/07 and checked by [Ms F] on 21/4/07. They were redressed on 22/4/07 as stated above; the top leg was sloughy and a further swab was to be taken the next day.

In my opinion, the Registered Nurse should have thoroughly assessed and developed a wound care plan on 19/4/07 to manage the risk of infection, particularly given [Mr A's] history of septic shock from his right hand previously. A Registered Nurse should have reassessed and redressed the leg wounds daily from 19/4/07 once it was established that the top leg wound was sloughy, again in order to minimise the risk of infection and to determine if and when medical intervention was required.

In my opinion, medical intervention was required on 19/4/07 due to [Mr A's] previous extensive skin sepsis on his right hand, as he probably should have been commenced on oral antibiotics while waiting for the swab result to return. A second swab was not required on 23/4/07 for the sloughy upper thigh wound, unless it was for a different wound. Instead, [the Home] should have phoned the laboratory for a preliminary report on the swab and then contacted the GP with the provisional results and requested a GP visit that day or at least a prescription of oral antibiotics.

In my opinion, the wound care given to [Mr A] for the right leg was inadequate, inappropriate and substandard and would be viewed with severe disapproval.

14. Please comment on the responsibility of [the Home] in relation to any requirement [Mr A] had for urgent medical review in the period 3 January to 23 November 2007.

[Mr A] was readmitted to [the Home] on 3 January 2007 as a privately paying permanent resident, following the episode of the right hand infection with subsequent septic shock requiring skin grafts on the hand. As previously discussed, [the Home] was ethically obliged to ensure that [Mr A] received at least the same level of care as that of the Subsidised Resident. The DHB Aged Care Residential Agreement for Subsidised Residents states:

D 16.7 Support Care and Intervention

e. Primary Medical Treatment

i You must ensure that:

3. Con-call emergency services are available to all Subsidised Residents at all times.

The progress notes describe an admission to hospital on 7/1/07 for [Mr A's] right hand and unwellness with his readmission to [the Home] on 11/1/07. However, the [public hospital] Discharge & Coding Summary describes [Mr A] being admitted to hospital on 9/1/07 with an episode of gastroenteritis and returned to [the Home] on

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11/1/07 with no notation of any admission on 7/1/07. Please refer to Question Sixteen for further comment in relation to the hospital admission on 7/1/07.

[Mr A's] right leg was injured on 15 April 2006. By 19 April the upper thigh wound was sloughy and the Registered Nurse had taken a swab of it. [Mr A] became unwell on 23 April and was admitted to hospital. Please refer to Question Thirteen for further details on the wound and the wound care given.

[Public] hospital's clinical notes (page 00210) states: *'R) leg (? Word) and swollen from knee down. Warm. Tender on palpitation … D/W Rest Home staff: R) leg swollen and (? Word) over past 2/7. R) knee usually appears N). [Impression] Cellulitis R) leg'*.

There is no evidence that [the Home] contacted the GP regarding urgent medical advice until the day of admission to hospital on 23 April 2007 to inform the GP that [Mr A] was being admitted from the documentation in Question Thirteen.

My Opinion

In my opinion, [the Home] was ethically responsible for ensuring that [Mr A] received urgent/emergency at any time of the day or night and that means that [the Home] must take responsibility to ensure that urgent medical attention is requested as soon as it is required. As discussed in Question Two, [Ms D] had a requirement that the Registered Nurses call her before calling in a doctor; this places an unnecessary barrier to obtaining urgent medical review and can cause delays. It is unacceptable for [the Home] to delay urgent medical attention by waiting for family availability to take [Mr A] to receive medical attention or by not ordering an ambulance for [Mr A] without having first phoned the Nurse Manager.

In my opinion, [the Home] should have requested [Mr A's] GP to visit him, or at least prescribe antibiotics over the phone, on the 19 April 2006 when the upper leg skin tear was noted to be sloughy with redness surrounding it. [Mr A's] previous medical history with the rapid overwhelming infection which had occurred with the right hand meant that [Mr A] was at a very high risk of developing an overwhelming infection in his leg. [The Home] made no attempt to seek medical advice or review of [Mr A's] leg over the next 3 days. On 23 April 2006, the handwritten notes describe the Registered Nurse being requested to review [Mr A] on arrival on duty at 8.30 am. At this point, the Registered Nurse should have not only checked the wound and taken observations of temperature, pulse, blood pressure, but also have contacted the GP immediately for urgent medical advice. I note also that on 23 April 2006 there are inconsistencies with the times of Registered Nurse review of the right leg with the documentation in the progress notes stating 11.00 and the handwritten note stated 8.30 am for the first request for the Registered Nurse to review [Mr A] and then a second request for review at 9.30 am.

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In my opinion, [Mr A's] upper thigh wound would have required urgent medical review at least two days prior from the admitting notes in [public] hospital clinical notes (page 00210) as these describe [the Home] staff saying [Mr A's] leg had been swollen for two days prior to admission.

In my opinion, [the Home], along with the Nurse Manager and Registered Nurses, failed in their duty of care and this would be met with severe disapproval.

15. Please comment on the standard of communication with [Mr A's] family.
Please refer to question ten.

16. Any other comment you wish to make.
Whilst writing this report, I noticed several inconsistencies in accounts of events and dates and also within the progress notes. I have chosen to discuss them within this question.

Page 00166 is a handwritten note (no date or signature of whom wrote it) discussing [Mr A] from 17th Sept until 13th Nov whilst at [the Home]. It states; '*1/ 17th Sept 06: [Mr A] was admitted for short stay care following bereavement. Tunnel surgery to R) hand … 2/ 09th Oct 06: [Mr A] had his L) hand tunnel surgery'*. The Description of Care Provided to [Mr A] from 17 September to 1 December 2006 (page 00061) states: '*17 September 2006 [Mr A] was admitted for a short stay care following bereavement. Carpal Tunnel surgery to right hand … 9 October 2006 [Mr A] had his Left hand carpel Tunnel surgery'*.

The transcript of interview of [Ms D], Nurse Manager, and [Ms E] by [HDC Investigator] and [HDC Investigator] on 8 November 2007 states: '[HDC Investigator]:*… we're looking into the development of infections that resulted in hospital admission. The first one was an infection to his hand that resulted in admission …; [Ms D]: This was the second hand that was done. The first hand healed beautifully;* [HDC Investigator]*: That was the carpal tunnel: [Ms D]: Yeah;* [HDC Investigator]*: It was the time when he was here and an infection developed that resulted in the full skin graft: [Ms D]: Yeah. It was a skin tear;… [Ms E]: From my recollection what happened was [Mr A] was a very restless sleeper by his own admission as well, and he hit his hand like in his sleep, he hit his hand; [Ms D]: It was his right hand'*.

The Complaint Action (page 00170) states: '*[Ms C] and [Ms B] explained that their father was admitted to [the Home] because he was about to have a carpal tunnel operation on his right hand. He had had a similar operation on his left hand earlier in the year, while his wife was still alive … Because their father had been brought up [in the area], they decided to admit him to [the Home] for his care, and he was admitted the day before his carpal tunnel operation, had the operation at [a private hospital] as a day case, and then went back to [the Home] … I put to [Ms B] and [Ms C] [the Home's] statement that their father had had*

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carpal tunnel surgery on 9 October 2006 (29 Nov 07 letter). They disagreed with this statement, as this operation had been done the previous month'.

The inconsistencies are that [the Home] informed HDC that the carpal tunnel surgery for the left hand was done on 09/10/06 when it was actually the right hand and done the day after his admission to [the Home]; that would have been 18 September 2006. [Ms D] also referred to the left hand instead of the right hand as being infected but corrected herself later in the interview.

The handwritten note (page 00166) discussing [Mr A] from 17th Sept until 13th Nov whilst at [the Home] states: '*8th Nov 06: [Mr A], while shaking his razor out of his ranch slider door to remove whiskers caught his R) hand and caused a skin tear. This was cleaned & dressed with paraffin gauze … 11th Nov 06: [Mr A] caused further injury to his hand by banging it on his bedroom wall at night … 13th Nov 06: [Mr A's] hand in the morning was noted to be swollen & inflamed. An ambulance was called @ 9.24 am to take [Mr A] to [public] hospital. [Mr A's] daughter [Ms C] informed who came to (? word) @ [the Home] then went on to the hospital'.*

Page 00188 is a St John Ambulance report form which refers to [Mr A's] R) hand, but has no date or time of transfer on it or from where the ambulance picked up [Mr A]. It states; *'R) hand & wrist swollen and dressed — advised pt has skin tear to R) hand and (? word) upper arm — also dressed. Rest home staff also state is not walking as well as normal'*. [Ms D's] letter to Rae Lamb, Deputy Commissioner, dated 17 November 2007 states: *'12 November 2006 [Mr A's] hand in the morning was noted to be swollen and inflamed. An ambulance was called at 9.24 am to take [Mr A] to [public hospital]. [Mr A's] daughter [Ms C] was immediately informed and came to [the Home] to accompany her father to hospital'.*

The transcript of interview of [Ms D], Nurse Manager, and Ms E by [HDC Investigators] on 8 November 2007 states: '*[Ms D]: we found it on a Saturday morning and on Monday you saw it and it looked fine and over night it just went off; Ms E: And then on the Tuesday morning I went to redress his hand and it was just quite awful and infected so I rang up his daughter [Ms C] and said that he needed to go and have it looked at which she took him to […] Hospital;… Ms E: So she took him to […] Hospital and from there he got admitted into [public hospital]'.*

The inconsistencies are as follows: [Ms E] referred to the daughter taking [Mr A] to […] hospital, and from there he was admitted to [public hospital]; the St John's ambulance report form insinuates that [Mr A] was picked up from the rest home due to their comments about his mobilisation as well as the handwritten note (page 00167) referring to an ambulance being called to take [Mr A] to [public hospital]. However, [Ms D] referred in her 9 September 2007 to Rae Lamb that the daughter took [Mr A] for medical attention and then in her 17 November 2007 letter to Rae

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Lamb that an ambulance was called to take [Mr A] to [public hospital] and that his daughter, [Ms C], came to the rest home to accompany [Mr A] to hospital. The date of admission to hospital is inconsistent as the handwritten note states 13th November and [Ms D's] letter dated 17 November 2007 states 12th November.

Further inconsistencies in relation to the date of the right hand event are as follows: [Ms D's] letter to Rae Lamb, Deputy Commissioner, dated 9 September 2007 (page 00077) states: *'On Saturday 16 December [Mr A] sustained a skin tear to his right hand by banging his hand on the bedroom wall … The dressing was renewed daily due to ooze. On the 17 December the wound had not changed. On the 18 December it was noted that his right hand was swollen and that the wound looked infected. He appeared to be in pain so we immediately contacted the daughter, [Ms C], who took her father for medical attention as he was still under his own GP care'*.

The handwritten note (page 00166) refers to the original skin tear occurring on 8 November as a result of catching his hand on his ranch slider door and further injuring it by banging his hand on his bedroom wall on 11 November, as stated above.

The Incident/Accident Report Form/Non Conformable form is dated 8/11/07 for the original hand injury. [Ms D's] letter to the A & E Registrar was dated 12/11/07 described a fall with skin tears on 8/11/07 and [Mr A] hit his hand on the night of 11/11/07 causing further injury.

The Transcript of Interview with [Ms D] (pages 00016 and 00017) states: '[HDC Investigator]*: We're satisfied he was actually …. he was admitted first … then he was admitted on 19 December but in fact he was transferred from the plastics department; [Ms D]: Not 19 December, that was from here wasn't it?; Ms E: Sorry, you're saying that he was admitted in November?;* [HDC Investigator]*: Yes;… [Ms D]: That wasn't the case;* [HDC Investigator]*: That was the case … I am just wondering, have you got any documentation at all that says what day this gentleman was admitted and transferred out of;* [HDC Investigator]*: [Ms D] wouldn't you have records of the time that he was staying with you, you would have to have those records for your financial??; [Ms D]: His initial admission was 17/09/06 and that extended to 9/10/06;…* [HDC Investigator]*: 9/10 yep, so that was the first respite care; [Ms D]: And then he went away. I haven't recorded when he came back, and nor has [Ms E] have you?; [Ms E]: No, no; [Ms]E: what date are they saying we admitted that this happened in November?;* [HDC Investigator]*: 13th of November;* [HDC Investigator]*: Presented to the emergency department 13th of November, with severe infection of right hand, with evidence of sepsis. And so it's quite clear'*.

[Ms D] states in her letter dated 17 November 2007 to Rae Lamb, Deputy Commissioner: *'8 November 2006… caught his right hand caused a skin tear …. 11 November 2006 [Mr A's] hand in the morning was noted to be swollen and*

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inflamed. An ambulance was called at 9.24 am to take [Mr A] to [public hospital]'.

The inconsistencies with the dates of the right hand event are: [Ms D] referred to the right hand sustaining a skin tear by [Mr A] banging his hand against the wall on Saturday 16 December when [Mr A] actually re injured his right hand on 11 November 2006. [Ms D] stated that the right hand was swollen and the wound looked infected on 18 December when they contacted the daughter to take [Mr A] for medical care. [Mr A] was actually admitted to [public hospital] on 12 November 2006 by ambulance. [Ms D] did not accept the right hand admission being in November when questioned about the December date in the Transcript of Interview with [HDC Investigator]; however, she did later change her version of the event date in her letter to Rae Lamb dated 17 November 2007 as above.

There is a further inconsistency with the documentation in the progress notes on 7/1/07 regarding [Mr A's] right hand injury and whether this notation actually refers to the hand injury and care given on 12/11/07. The progress note entry for 7/1/07 is sequentially documented within the progress notes which commenced on [Mr A's] readmission to [the Home] on 3 January 2007.

[Mr A] became unwell and was admitted to hospital on 7/01/07 with severe pain in his right hand, was unwell and febrile, as stated in the progress notes (pages 00146 & 00147): *'7/1/07 12.00 At approx 11.30 was called to assess [Mr A] who was at that time having rigors. He c/o of intense pain in his Rt hand. BP & Pulse stable T 38.3 (120/77, P 88). At approx 13.00 c/o of pain in his R ear and top of neck region. C/o of no pain in chest or nil pain radiating … Ambulance rang again to inform them of blood pressure dropping. Daughter [Ms B] in hospital unable to locate other daughter [Ms C] as apparently [Mr A] says has gone on holiday. Informed the hospital on covering letter how I hadn't been able to contact family'*. The next notation in the progress notes describes [Mr A's] return from hospital as stated: *'11/1/07 11.00 Returned from [public hospital] following episode of Gastroenteritis. IV Fluids given for rehydration. Commenced a course of oral ciprofloxacin … dressing / bandage insitu on R) hand & dressing on L) elbow'*. [Ms F's] typed report (page 00162) states: *'On 07/01/07 at approximately 11.30 hrs whilst attending to two patients requiring hospital admission I was asked by a caregiver to review [Mr A] who was complaining of feeling cold and having pain in his right hand. She said that [Mr A] had told her he had knocked his hand trying to open his window from the outside earlier in the day. Approximately five minutes later after attending to the residents waiting for the ambulance, I went to see [Mr A] who was complaining of bad pain in his right hand and was shivering … Temp 38.3 BP 120/77 and Pulse 88 …. At approximately 13.00 hrs [Mr A] complained of pain in his right ear and the top of his neck. At this time his Temp 38 Pulse 83 and his BP had dropped to 108/48'*.

There is no documentation within [the DHB] file that has been provided regarding the admission on 7 January 2007 nor a copy of [Ms F's] letter to the hospital. [The

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DHB] Public hospital Discharge & Coding Summary (page 00139) admission and discharge dates do not support an admission to hospital on 7/1/07; the Summary states: *'Admitted 09/01/07 12.48; Diagnoses Primary Diagnosis — Gastroenteritis; Secondary Diagnoses — skin sepsis R) hand 12/06 > E. Coli — skin graft R) hand > d/c 3/1/07 … Discharged On: 11/01/2007 08.15; Clinical Management Since discharge on the 3/01/07 from orthopaedics [Mr A] had been well. However the night before admission develop loose and watery bowel motions. Associated with fevers and rigours …. No discharge from graft site … Skin graft red, but not hot or tender and no ooze'*. This Discharge & Coding Summary is the only documentation of the admission with Gastroenteritis within the file provided.

[Ms D's] letter to the Health and Disability Commissioner dated August 11 2007 (page 00130) states: *'**Re: Paragraph 2** This paragraph mentions that [Mr A] rolled out of his small bed and sustained a skin tear on the back of his right hand … We have no evidence that [Mr A] rolled out of his bed — he admitted to us, however, that he was a very restless sleeper and often threw his hands out of the bed and in so doing repetitively hit the wall which we believe that was the cause the skin tear. Please refer to the attached documented report by one of our Registered Nurses, [Ms F] (dated 7/01/07), which outlines the full circumstances relating to this incident and the care given'*.

The letter of complaint from [Ms B], daughter dated 10 July 2007 (page 00001) paragraph two states: *'He had only been there about three months when he rolled out of his small bed and sustained a skin tear on the back of his right hand. Within a short time (four days) it had become infected … No swab was taken and he was admitted to [public hospital] on the Monday in septic shock, about seven days following the fall'*. I note the letter of complaint from the daughter does not refer to a hospital admission for [Mr A's] right hand on 7/1/07.

[Ms D's] letter is in response to the letter of complaint from the daughter and refers specifically to paragraph two. Paragraph two in the letter of complaint is discussing [Mr A's] admission to hospital with septic shock from his right hand injury; this admission occurred on 12 November 2006. This highlights an inconsistency and leads me to believe that the 7/01/07 entry in the progress notes and [Ms F's] report dated 7/01/07 actually refer to the event on the night of 11 November when [Mr A] hit his right hand re injuring it and was admitted to [public hospital] on 12 November 2006. If the progress notes were written retrospectively this brings into question the validity of the progress notes in general.

[The Home] supplied policies and procedures that relate to dates subsequent to [Mr A's] tenure in [the Home], apart from the Wound Management policies and procedures which had 1999 dates. [The Home] went through a surveillance audit on 29 November 2006; this leaves me with the impression that the policies and procedures supplied by [the Home] with review dates of September and November 2006 were especially developed/reviewed before the surveillance audit was

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conducted. The Wound Management policies and procedures have a lot of information that is not required for staff and makes it more user unfriendly to read and follow. The information within the Wound Management policies and procedures needs to be updated to align with current best practice.

The lack of and/or calibre of policies and procedures apparently available to [the Home] staff between 17 September and 23 April 2007, as supplied/not supplied by [the Home], is a concern and does not align with the requirements of Certification with the Ministry of Health.

In summary the documentation reviewed in this complaint reflects a direct response from the rest home proprietor to this complaint in its obvious retrospective nature. The benchmark of this particular resident makes me question [the Home's] overall practice for all residents and showed there to be segregation of care for subsidised and private residents, therefore I conclude that the care given to [Mr A] was not in accordance best practice and required standards for rest home care as cited in my report.

In my opinion, the Nurse Manager and Registered Nurses breached the New Zealand Nursing Council's Code of Conduct for Nurses and Midwives in the following areas: Principle Two: 2.1, 2.2, 2.4, 2.5, 2.9, Principle Three: 3.2, 3.5, 3.6 and Principle Four: 4.3, 4.5 4.6, 4.9. I believe that the Nurse Manager and the Registered Nurses also breached the New Zealand Nursing Council's Registered Nurses Competencies.

Jenny Baker"

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