Bupa Care Services NZ Limited

Care Manager, RN C

Unit Coordinator, RN D

Registered Nurse, RN B

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC00423)

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms A was a younger resident in a rest home and hospital (the facility) in Month7[1]. She required hospital-level care.

2. Ms A suffered from multiple sclerosis (MS)[2] and, as a result, was paraplegic and largely bed bound, blind in her left eye, and required a long-term urinary catheter. She was also diabetic, requiring insulin, had a cardiac pacemaker for complete heart block, and suffered from syndrome of inappropriate anti-diuretic hormone secretion (SIADH)[3] and depression.

3. Ms A was prescribed zopiclone for insomnia. From 1 Month5, following review, her GP, Dr E, charted an additional dose of zopiclone PRN nocte. Often the second dose of zopiclone was administered at her request between 2am and as late as 6.30am. This caused her regular daytime sleepiness and associated reduced appetite and nutrition.

4. On 2 Month7, one of Ms A's caregivers observed a pressure area on her sacrum. A wound care plan and an evaluation record were commenced and, over the next week, the wound area was re-dressed regularly.

5. On 9 Month7, Dr E assessed the pressure wound as superficial. He expected it to respond well to good nursing care.

6. Unfortunately, the sacral pressure wound did not respond well, and from that evening began to deteriorate.

7. Over the next fortnight, nursing staff undertaking wound care recorded the increasing deterioration in the wound, and in Ms A's general condition. However, no action was taken to refer Ms A to a wound care specialist nurse or to seek a reassessment by Dr E.

8. On 20 and 21 Month7, nursing staff noted Ms A's deteriorating general condition and diminished appetite. The sacral pressure wound was noted on 21 Month7 to have deteriorated again, but no further medical advice was sought. The same day, Ms A was administered zopiclone at 2pm.

9. On the morning of 23 Month7, Ms A was found to be unresponsive by staff. By the time her vital signs were taken in the early afternoon, she was acutely unwell with a high fever, low blood pressure, diabetic ketoacidosis, and shock. The GP's practice was alerted by fax and telephone call, and two hours later recommended that Ms A be sent to Hospital 1 by ambulance.

10. Ms A was transferred to Hospital 2, and underwent urgent surgical debridement of the sacral pressure wound. Postoperatively, despite maximum inotropic support and ventilation,

[1] Relevant months are referred to as Months 1-7 to protect privacy.

[2] A chronic degenerative disease of the central nervous system marked by patchy destruction of the myelin that surrounds and insulates nerve fibres. It is manifested by neural and muscular impairments, including spastic weakness in the limbs, local sensory losses, and bladder dysfunction.

[3] Characterised by excessive release of the antidiuretic hormone, resulting in an increase in water/fluid within the body.

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her condition became unsupportable. Sadly, Ms A died from septic shock as a result of necrotising fasciitis associated with the sacral pressure wound.

Findings

11. From 15 Month7, staff at the facility failed to assess, think critically, and act appropriately in response to Ms A's deteriorating wound and general condition. Staff repeatedly continued to administer zopiclone PRN at inappropriate times without reference to the prescriber to seek advice. Accordingly, Bupa Care Services NZ Limited (Bupa) failed to provide Ms A with services with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[4]

12. As Clinical Manager, with responsibility for high level clinical leadership and support to clinical and care staff, RN C failed to act on information relating to wound deterioration from 15 Month7, and to respond appropriately to Ms A's acute presentation on 23 Month7. RN C thus failed to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

13. The Unit Coordinator, RN D, failed to act on wound management issues, and responded inappropriately when Ms A was found to be acutely unwell on 23 Month7. RN D did not provide services to Ms A with reasonable care and skill. Accordingly, RN D breached Right 4(1) of the Code.

14. In relation to wound management and the administration of PRN zopiclone, Ms A's allocated nurse, RN B, did not provide services with reasonable care and skill to Ms A during Month7, in breach of Right 4(1) of the Code.

15. Adverse comment is made in respect of the oversight of the administration of PRN zopiclone by the prescriber, Dr E.

Recommendations

16. It is recommended that Bupa update HDC on the finalisation and implementation of the Pressure Injury Prevention and Management policy and education pack, and the Short Term Care Plans policy; its implementation of the electronic medication management and electronic incident management systems; its Clinical Manager Framework and Orientation Programme; the position description for the Clinical Manager; and the implementation of the proposed new role of roving Clinical Manager.

17. It is also recommended that Bupa, RN C, RN D, and RN B each provide a written apology to Ms A's family.

18. Bupa, RN D, and RN B have been referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

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

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Complaint and investigation

19. The Commissioner received a complaint, referred by the Office of the Coroner about the services provided to Ms A (deceased) by the facility.

20. The following issues were identified for investigation:

- *The appropriateness of the care provided by BUPA Care Services NZ Limited trading as the facility to Ms A (dec) in [20xx].*
- *The appropriateness of the care provided by Clinical Manager RN C to Ms A (dec) in [20xx].*
- *The appropriateness of the care provided by Unit Coordinator/Registered Nurse RN D to Ms A (dec) in [20xx].*
- *The appropriateness of the care provided by Registered Nurse RN B to Ms A (dec) in [20xx].*

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

22. The parties directly involved in the investigation were:

Complainant/consumer's sister	
Bupa Care Services NZ Limited	Provider
RN C	Clinical Manager
RN B	Registered nurse
RN D	Unit Coordinator/registered nurse

23. Information was also reviewed from:

Dr E	General practitioner
Medical centre	Provider
Mr G	Care Home Manager
RN H	Clinical Manager/registered nurse
RN I	Registered nurse
RN J	Registered nurse
RN K	Registered nurse
RN L	Registered nurse
Coroner	
District health board	
The Ministry of Health	

24. Expert advice was obtained from HDC's nursing advisor, registered nurse Dawn Carey (**Appendix A**), and clinical advisor, vocationally registered general practitioner Dr David Maplesden (**Appendix B**).

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Information gathered during investigation

Ms A

25. In [20xx] Ms A was a hospital-level resident at the facility. She had transferred there to be closer to family.

26. Ms A was bed bound because of debilitating progressive MS. She was dependent on insulin for diabetes, and had had a cardiac pacemaker since 2006. She also suffered from SIADH and depression. As a result of the MS, Ms A was paraplegic, blind in her left eye, and required a long-term urinary catheter.

27. Ms A required complete assistance with her personal cares, and two people to transfer her to a wheelchair and to turn her in bed. She was able to — and did from time to time — express her preferences for her diet and regarding her cares.

28. This report considers Ms A's care while at the facility in [20xx] after she developed a sacral pressure wound.[5] During this time, a number of errors were made in her care, particularly in relation to her wound management, zopiclone administration,[6] and her nutritional status. Ms A's condition deteriorated, and she died in a public hospital.

The facility and staff

29. The facility is owned and operated by Bupa Care Services NZ Limited (Bupa), and achieved a three-year certification from the Ministry of Health in in the year prior to Ms A's admission. At the time of these events, it was supervised by a Clinical Manager (CM), as well as a Unit Coordinator (UC). On every shift, a registered nurse (RN) was on duty, together with two caregivers.

30. A visiting general practitioner (GP) made rounds in the facility twice each week. The rounds alternated between the hospital and the rest home wings, and staff could request a GP visit for any patient by writing in the GP's diary. Staff could also arrange referral for external wound specialist nurse review from the district health board.

Clinical Manager

31. RN C was the Clinical Manager at the facility, having commenced in the role that year. She had had no previous experience in a clinical manager role, but had extensive experience, including within specialist infection control roles at district health boards. RN C reported to the Facility Manager (FM),[7] and her role was to provide high level clinical leadership and support to clinical and care staff.

Orientation of Clinical Manager

32. RN C commenced formal responsibility as Clinical Manager on 18 Month6, following a period of orientation including two weeks alongside an experienced clinical manager, RN H, at another Bupa facility. RN H told HDC that during this time, RN C accompanied her (RN H) on her rounds each morning, and followed her normal daily routine. RN H

[5] Documentation reviewed by HDC variously describes the sacral pressure wound, including as a pressure sore, pressure injury, pressure area, wound, and ulcer. In this report, the term "pressure wound" is used, except where a direct quotation is cited.

[6] Zopiclone is a short-acting hypnotic drug prescribed for insomnia.

[7] Also referred to by respondents to HDC as the Care Home Manager (CHM).

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confirmed that RN C was orientated to systems and processes, including reading and signing off Facility Manager reports and reviewing progress notes of any resident of concern noted in the Facility Manager report or verbally handed over by staff.

33. RN C said that her orientation did not cover all aspects of the job, and "focused on staff roster management, reporting of key quality indicators and staff education and competencies". She stated that it did not include some aspects, including many site-specific orientation matters, probably owing to circumstances, because the previous clinical manager had already left, and the acting clinical manager was not aware of every aspect of the role.

34. Bupa confirmed that a new Facility Manager, Mr G, had recently commenced in his role at the facility. Bupa also provided a copy of the "CM Orientation Record Book". The orientation period is three months, and should include a "follow-up" meeting half-way through that period, to identify issues the new employee is unsure of, and those about which the employee seeks more information.

35. The six-week follow-up meeting for RN C should have taken place about 8 Month7. Bupa acknowledged that a six-week follow-up meeting did not take place, "due to a change [to] the newly appointed manager, RN C's sporadic sick leave,[8] her mislaying her orientation book and the Operations Manager not being clear enough regarding the responsibility to complete the review". However, Bupa said that RN C also had a responsibility to drive this meeting, and that she did not.

36. RN C told HDC that during Month7 the new Facility Manager, Mr G, was away on holiday. She stated that during that time, Bupa was unable to get cover the whole time, and that she worked without a Facility Manager for "a couple of weeks". RN C said that she raised a concern in a senior management meeting that she would be on her own so soon after starting, but felt that her concerns were "brushed aside". RN C stated:

> "At the time, in the lead up to [Ms A's] death, during the month of […], while the FM was away and so soon after starting the job, I was feeling extremely overwhelmed and not very well supported in my new role."

37. While Bupa acknowledged that there was fragmented cover in senior management during some of this period, it advised HDC that the period over which FM Mr G was on pre-arranged leave was from 29 Month7 to 27 Month8.

Unit Coordinator

38. At the time of these events, RN D had worked in the role for three years. Prior to that, she had worked as a nurse at the facility for two years.

39. RN D told HDC that, as Unit Co-ordinator she was responsible for ensuring that various reviews were conducted, including medical, medication, and multi-disciplinary reviews.

Registered nurses

40. RN B was Ms A's allocated nurse. She was responsible for ensuring that Ms A's assessments and care plan were reviewed every six months, before the resident review, or sooner if there were any major concerns or changes.

[8] Bupa advised HDC that RN C had a total of 14 days' sick leave during her first three months of employment.

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41. RN B commenced employment as a registered nurse at the facility in Month4. She completed her nursing degree overseas, and had been employed as a nurse in a general hospital for around two years before moving to New Zealand. This was RN B's first position as a nurse in New Zealand and in aged care.

42. RN K was employed at the facility as a registered nurse from Month1 for about a year. Prior to this she was employed as a healthcare assistant at another facility and had worked overseas for four years at multi-disciplinary hospitals.

43. RN J qualified overseas, and was employed in a surgical ward of a hospital from 2009 to 2011. She became a registered nurse in New Zealand in 2012, and was then employed at the facility.

Processes/policies for sharing information

44. Bupa provided HDC with a copy of the Manager's Report book for this time. Its policy states that the Report is to be completed at the end of each shift by the qualified nurse or duty leader, and it is the Facility Manager's and Clinical Manager's responsibility to read the report daily and "ensure effective follow up of items reported has occurred".

45. RN B told HDC that, in addition to the Manager's Report, information was shared with the Clinical Manager every weekday at the 7am handover.

46. RN D described meetings that formerly took place once a week, where the Unit Coordinator, Clinical Manager, and Facility Manager would discuss residents, especially those with concerns. However, RN D said that this practice was stopped by RN C and the Facility Manager, Mr G, as they did not see them as necessary. RN D said that the meetings were restarted after these events.

47. RN J stated that while she was aware that a registered nurse could arrange for a wound specialist review:

> "… the practice had been that the Clinical Manager would make such referrals. However Registered Nurses would bring concerns about the condition of residents to the attention of the Clinical Manager. This would be done through a report in the Facility Manager's book … or the Clinical Manager was occasionally present for the morning shift handover … The GP was in the facility twice a week and Registered Nurses could write in the GP's diary book if they wished a particular patient to be seen."

48. RN D noted that the facility "had previously had a nurse who had the wound care portfolio" but he had left and not been replaced in [this] period.

Sacral pressure wound

49. Shortly after her admission to the facility in late Month1, Ms A was placed on an air mattress. It was recorded in her Care Plan that she was to be turned two hourly in order to prevent the development of pressure sores. However, on 8 Month2 the mattress was removed at her request, as it was causing her discomfort. In Month2, Ms A also asked staff not to disturb her sleep at night by turning her two hourly unless she requested for them to do so.

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50. On the evening of 2 Month7, a caregiver discovered a pressure wound on Ms A's sacrum. The caregiver informed the nurse on duty, RN J, and completed an incident form. RN J recorded in the progress notes:

> "The pressure injury noted on her sacral area extending down to buttocks is a Grade 1 pressure sore,[9] non-blanchable redness … skin intact … [w]ound noted to be 12 cm in length and 16 cm in width, not in pain on area when doing the wound care. [Ms A is] aware of the need to be turned on her sides every 2-hourly, instructed her to lie on her back only during meals."

51. RN J cleaned the area and applied a protective dressing. Ms A was moved onto her side in bed and advised to stay off her bottom.

52. RN J completed a Short Term Care Plan[10] and Wound Initial Assessment and Plan, which included a Wound Management Plan section, in accordance with Bupa's policy entitled "Wounds — Management of". The Wound Initial Assessment and Plan recorded, in particular: "Monitor healing process of wound. May need to review Wound Management Plan if wound is deteriorating or unchanging." The Wound Management Plan directed that the dressing on Ms A's pressure wound be replaced every 5–7 days or as needed.

3 to 8 Month7

53. On 3 Month7, RN D recorded that Ms A had described her right eye as "sort of rolling", and that she was having hallucinations. RN D noted that Ms A's MS might be causing the problem with her eye, and that the hallucinations could be caused by tramadol, but that Ms A said that she liked tramadol for treatment of pain in her left shoulder. When Dr E saw her later that day, his impression was that Ms A's symptoms in her right eye were a result of exacerbation of her MS.[11]

54. From 3 to 8 Month7, the wound documentation[12] and progress notes record steps taken to manage the pressure wound and Ms A's health.

55. At 11.15am on 3 Month7, RN D and RN C discussed with Ms A the management of her pressure wound. Ms A declined the use of an air mattress because she found it uncomfortable. She agreed to be turned every two hours during the day whilst awake, but requested not to have her sleep disturbed.

56. RN C made a note to offer the air mattress again and to get the GP to discuss this with Ms A if she declined it again. RN C also directed staff in writing to commence a two-hourly turn chart, noting that staff should ask Ms A every two hours if she wanted to be turned and, if not, they should record in her turn chart that she declined.

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[9] The "Waterlow" grading system has four recognised grades of pressure wounds. Grade 1, the least serious, refers to discolouration of intact skin not affected by light finger pressure (non-blanching erythema).

[10] Which included the need for two-hourly turns and for Ms A to remain on her back only for meal times.

[11] Dr E later discussed the symptoms with Ms A's physician at Hospital 2, who advised against treatment with steroids in light of Ms A's previous lack of response to prednisone and her risk of infection.

[12] Incident form, Short Term Care Plan, Wound Initial Assessment and Plan (incorporating Wound Management Plan) and Wound Evaluation Chart.

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57. On the evening of 3 Month7, RN J noted that the left-hand side of Ms A's mouth was slightly lower and drooping compared with the right-hand side of her face. RN J documented that Ms A said that she was very sleepy that day, and that she thought she could have had a minor stroke unknowingly. RN J told HDC that Ms A's speech was slurred and difficult to understand, but that this was not unusual for Ms A.

58. On 4 Month7, nurses noted that Ms A was not very settled, with ongoing pain in her left shoulder, which was why she refused to be turned during the night. At times she was teary and emotional, and had a "small appetite".

59. A Wound Evaluation Chart (evaluation chart) was commenced, which recorded the size, condition, margins, presence of infection, exudate, and a general evaluation of Ms A's pressure wound.[13] RN J recorded no change to Ms A's wound. She noted that the skin was intact, and that the wound was re-dressed.

60. On 7 Month7, Ms A's risk assessments were updated by RN B. The Braden Scale score identified Ms A's potential risk of pressure injury as 14 (indicating moderate risk).[14] The Mini Nutritional Assessment form (MNA) reported Ms A as "malnourished".

61. On 8 Month7, RN L evaluated and redressed Ms A's pressure wound. RN L recorded in the evaluation chart that it was unchanged, with 90% epithelialising (pink) tissue and 10% granulating (red) tissue.

62. Between 3 and 8 Month7, Ms A was turned regularly during the day. She complained of continued shoulder pain, for which Panadol and tramadol were given.

9 Month7

63. At around 11am on 9 Month7, RN K transferred Ms A to the shower chair, and a caregiver showered her. RN K said: "After the shower, [Ms A's] dressing was removed and the wound was covered with sterile gauze pieces in anticipation of the GP review."

64. Dr E reviewed the pressure wound with RN D.[15] He told HDC that he noted redness and a dusky blue appearance to the skin. He stated: "[Ms A's] weight had increased to 58kg (admission weight was 54kg) and her blood pressure (120/88), temperature (36.3) and pulse (70) taken on 4 [Month7] were normal." Dr E said that at this time Ms A's blood sugar levels were stable (8.7). Dr E did not order blood tests because he did not consider her to be malnourished, and he did not alter her charted prescription or "as required" medications. Following this review, Ms A agreed to the use of the air mattress, which was placed on her bed. Dr E considered that with two-hourly turns, the use of the air mattress, and good nursing care, the pressure wound should heal.

65. Dr E said that he did not schedule a further review of Ms A, and that in accordance with the practices in place at the facility, he expected the nursing staff to contact him should there be any concerns or deterioration to the pressure wound.

[13] The evaluation chart was further updated on 8, 9, 10, 13 15, 17, 21 and 23 Month7.

[14] The Braden Scale is a predictive tool for assessing risk of developing a pressure injury. A score of less than 9 indicates severe risk, high risk 10–12, moderate risk 13–14, and mild risk 15–18.

[15] Dr E's consultation notes of this review were completed at 11.19am.

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66. The wound site was not re-dressed for some hours after Dr E's review. RN K said that she cannot recall all of the details of that day, but she believes that she must have been very busy, which is why she was unable to re-dress the wound before she finished her morning shift.

67. RN K handed over to the registered nurse on shift that afternoon to re-dress the pressure wound. She also recorded her handover in the Facility Manager's Report (Manager's Report). RN K said that, in the meantime, she ensured that the wound was not exposed by re-applying sterile gauze after the GP review, and that RN C was also aware that RN K had been unable to dress the wound.

68. Bupa told HDC that RN I said that Ms A declined to have the pressure wound dressing renewed that afternoon shift and, therefore, she had to hand over to RN B to complete this task on the next shift. Bupa said that often Ms A was unable to be persuaded to do anything she did not want to do, and therefore when Ms A refused to have the dressing renewed, staff accepted her right to refuse. However, there is no record that Ms A refused to have her wound dressed, and an entry in the Manager's Report the following morning recorded that the shift nurse "got handover that [Ms A's] pressure wound dressing wasn't done the whole of yesterday because staff were busy".[16]

69. Ms A's daughter told HDC that she telephoned her mother on the evening of 9 Month7, and her mother told her that she had bed sores because the nurses were not turning her. Her mother also said that one of the nurses was pregnant and not allowed to turn her, so when that nurse was on shift, she did not get turned at all. Ms A's sister also spoke with Ms A that day and told HDC that during these discussions her sister commented that she was not being turned at night, owing to a carer being pregnant and refusing to turn her.

70. That evening, for the first time, a change was noted in Ms A's pressure wound. At 10pm Ms A's bottom was washed, and a caregiver recorded: "[V]ery red, broken skin, black spots on either side. RN notified …" RN B noted in the evaluation chart that the wound was deteriorating, with an increase to 20% granulating tissue and a low level of exudate where previously there was none. No change was made to the Wound Management Plan.

10 Month7

71. At 6.30am on 10 Month7, RN B checked on Ms A and found that the pressure wound had been exposed in the night. RN B said that she tried to reapply the dressing, but Ms A was sleepy and refused.[17]

72. RN D later re-dressed the wound and recorded in the evaluation chart that it had deteriorated, with tissue that was 5% necrotic (black), 15% sloughy (yellow), 20% granulating, and 60% epithelialising. She also recorded that there was a slight odour and a low amount of exudate. No change was made to the Wound Management Plan.

11 Month7

73. On 11 Month7, RN D was on night shift. She documented that Ms A was asleep each time she checked, so she did not turn her until around 5.45am, when Ms A woke and used the

[16] The entry appears to have been made by RN D.

[17] On 11 Month7, RN B wrote a retrospective note in the progress notes recording this.

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call bell. Ms A requested tramadol and zopiclone. Although RN D attempted to dissuade her from taking PRN zopiclone at this time, Ms A was insistent, and the nurse acquiesced. This was recorded in the charts and progress notes. RN D also recorded in the Manager's Report:

> "[Ms A] requested for Tramadol and Zopiclone at 0550hrs. Explained to [her] that it was already morning for a sleeping tablet but she insisted hence I gave it to her."

13 Month7

74. On 13 Month7, RN J updated the evaluation chart, summarising "slight deterioration" of the pressure wound and recording tissue that was 5% necrotic, 20% sloughy, 20% granulating, 50% epithelialising,[18] odorous, and with a low level of yellow and red exudate. Ms A's dressing was changed again. RN J applied Intrasite gel[19] in addition to the dressing, and recorded this on the evaluation chart, but no change was made to the Wound Management Plan.

15 Month7

75. On 15 Month7, the pressure wound had again deteriorated. RN I recorded in the evaluation chart a moderate amount of yellow exudate and a very foul smell, noting: "The pressure sore looks really bad …" The tissue was noted as 10% necrotic, 40% sloughy, 10% granulating, and 40% epithelialising. In addition, RN I recorded that the wound was causing Ms A pain. RN I cleaned and re-dressed the wound. She informed the next nurse on duty, RN B, and recorded in the Manager's Report:

> "[Ms A]:- Her dressing has (sic) done on sacral region as it was dirty after she opened her bowel. The pressure sore looks deterioration with yellow pus around the area. She was in pain while doing the dressing …"

16 Month7: multi-disciplinary review meeting and Dr E's rounds

76. On 16 Month7, a multi-disciplinary review (MDR) meeting took place to review Ms A's care. The meeting was led by RN B, and attended by RN C, the activities coordinator and a psychologist.

77. The MDR meeting minutes record that Ms A had a "pressure area" on her sacrum, that she liked to choose her own food and amount, and that her weight had increased by 3kg within three months. RN B recorded that Ms A could be turned two hourly during the day, but that she did not want to be disturbed during the night except for when providing her sleeping pill at 10pm.

78. RN C told HDC that at the review no concerns about the wound were discussed, and that the focus was on Ms A's personal matter.

79. The same day, Dr E attended the facility for his usual rounds. Ms A was not included in the list of patients to be seen. He told HDC that he made enquiries with staff as to Ms A's condition, and was advised that there were no concerns with her.

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[18] It is noted that the percentages as recorded do not equal 100%.

[19] Intrasite gel is a topical desloughing and debriding hydrogel.

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17 Month7 — nutritional intake declines

80. From 17 Month7 onwards, Ms A was consistently noted to be quieter, with a low mood, and eating less and, at times, refusing to be turned. Staff made regular entries in the Manager's Report about Ms A's condition, indicating general deterioration.

81. Bupa told HDC that frequently Ms A would decline the meal options offered to her and, despite her diabetic status, she enjoyed eating foods high in fat and sugar. Bupa said: "As [Ms A] was competent to make her own decisions, we believe staff accepted that this was Ms A's right to choose."

82. At the end of her shift on 17 Month7, RN D recorded in the Manager's Report that Ms A was "very depressed", had eaten well at breakfast but declined everything at lunch. RN D told HDC:

> "There were days that [Ms A] would eat well with assistance and at times she would just eat a little of the meal prepared by the kitchen but would eat her own ice cream, non-diabetic coke and lollies despite being a diabetic patient on insulin. We tried to ensure that [Ms A] ate a healthy diet but this was not always easy."

83. RN C acknowledged to HDC that something more should have been done to ensure adequate intake for Ms A and to monitor and assess the effectiveness of any interventions. RN C said:

> "I was told [Ms A] wasn't eating/hungry a couple of days after her multi-disciplinary review (around 16–17th [Month7]) and knew from her review that she liked ice-cream, so told the staff member to get her some of that. I wasn't told anything else, and I knew that [Ms A] was sad from […], and without being informed of any other concerns or given any further information thought that that was why she wasn't eating."

84. Later on 17 Month7, RN J recorded that the pressure wound had further deteriorated, with an increase in sloughy tissue to 50% (and a corresponding 10% decrease in epithelialising tissue). It remained odorous, with a moderate amount of yellow exudate, and the wound margins were noted to be slightly inflamed. RN J changed the Wound Management Plan by amending the dressing from "Warm saline + Replicare Ultra" to "Warm saline + Allevyn", and amending the frequency that the dressing was to be changed from "5–7 days or as needed" to "6–7 days or as needed". All other aspects of the Wound Management Plan were unchanged.

18 to 20 Month7

85. Progress notes reflect that Ms A was continuing to eat and drink very little, was less active, had low mood, and was not talking much during this period.

86. On 18 Month7, RN D recorded in the Manager's Report that Ms A "[r]emain[ed] depressed" but tolerated Weet-Bix well when assisted, and half a tomato sandwich and her ice cream for lunch, and had ordered dinner. At 10.40pm a caregiver recorded that Ms A was "very upset this shift", had eaten very little dinner, and had declined all cares and turns.

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87. On 19 Month7, RN D again recorded in the Manager's Report: "[Ms A] remains depressed. Little food intake, but drinking well. Handed over to the incoming shifts to refer the social workers to [the Facility Manager] to deal with this issue."

88. On 20 Month7, RN I recorded: "[N]ot drinking well. [Ms A's] condition of health is deteriorating." Following this, at 10.50pm RN I checked Ms A's vital signs and recorded them, as she found her "too cold". Ms A's oxygen saturation level was 90%. The observations did not include her respiratory rate. There is no record of other action taken to manage these observations.

89. RN I told HDC that Ms A often appeared depressed and was refusing food, two-hourly turns, and cares, despite staff encouragement. RN I also said that nurses passed on this information in the handover, and documented it in the progress notes, as well as completing the wound evaluation whenever doing the dressing. She stated:

> "I clearly handed over everything which involves her wound condition and food intake level to the next RN to inform the Clinical manager/Unit co-ordinator who will be doing doctor's rounds and referrals, and she was notified too."

90. At 10.45pm on 20 Month7, RN K started the night shift. She told HDC that she does not remember any specific concerns being raised by the nurse on the previous shift, who had taken Ms A's observations late on 20 Month7.[20] Although the observations showed that Ms A was cold and her oxygen saturation low (90%), RN K recalled that Ms A always slept with her windows open, and that, as a result, her extremities could become cold at night. RN K believed that this could also have impacted on the accuracy of the oxygen saturation reading, and she does not recall being concerned by it at the time.

21 Month7

91. RN K conducted regular visual checks on Ms A through the early hours of the next morning, but did not wake her, in accordance with Ms A's preference.

92. At 2.45am on 21 Month7, RN K recorded:

> "On appearance (she is breathing). She is looking too much deteriorated. The light in her room has [been] turned on throughout the night to check on her regularly. She did not ask to turn it off either. She is just accepting all the things now at this stage. May be because she is sleeping and she doesn't know that the lights are on."

93. At 6.40am RN K recorded that Ms A appeared confused and was experiencing visual hallucinations. RN K noted that she had not provided Ms A zopiclone and tramadol when requested at 6am, and that "[Ms A] already appeared to be low and overdosed". RN K told HDC that she was aware that Ms A had been seen by Dr E on 3 Month7, and had understood from his notes that the hallucinations were a symptom of Ms A's worsening MS. RN K said that she "considered seeking after hours medical advice, however the confusion and visual hallucination ceased after a few minutes". RN K also recorded that she attempted to take Ms A's observations, but Ms A refused, saying that she was "sleepy".

[20] RN K told HDC that she was referring to RN I.

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94. During her shift on 21 Month7, RN B evaluated the pressure wound and recorded in the evaluation chart a further deterioration, with now 20% necrotic tissue and a corresponding 10% decrease in sloughy tissue. There was a moderate amount of odorous yellow and red exudate, and the wound margins were noted to be macerated.[21] In addition, Ms A continued to experience pain from the pressure wound. RN B cleaned and re-dressed the wound, with no change to the wound dressing section of the Wound Management Plan.

95. RN B said that, during handover, the night nurse explained to her that Ms A was depressed, she was refusing food and cares, and her blood sugar levels were increasing. RN B said that she was told to try to get Ms A to eat, and to do her cares and make her comfortable.

96. A caregiver recorded that Ms A ate around a quarter of her breakfast and around half a serving of ice cream for lunch, as she declined the main meal.

97. At 10.30pm RN I recorded that Ms A remained depressed and was not verbally responsive, but made some noises as replies. With RN I's assistance, Ms A had ice cream for dinner.

22 Month7

98. On 22 Month7, a caregiver recorded that Ms A was in a very low mood, declined turns, ate no breakfast, but had some ice cream for lunch. RN B washed Ms A. RN B remembers discussing with RN C at handover that morning that Ms A was depressed and refusing cares and food. RN B stated: "I said something along the lines of 'Have you seen what [Ms A] is doing? [re: refusing everything] She is going downhill.' The CM replied that she was aware of that." However, there is no record of this discussion.

99. That night, RN I again noted Ms A's lack of responsiveness. According to the records, Ms A ate ice cream for dinner but would not open her mouth for fluids or medication. RN I recorded Ms A's temperature as 36.5ºC and noted that she had redness measuring 5cm in width and 6cm in length on the left-hand side of her neck. RN I wrote: "[H]anded over to the staff to monitor."

100. At 1.25am on 23 Month7, RN J noticed that Ms A was awake, and asked if she wanted to be turned. However, Ms A was not responding to questions verbally or with gestures. RN J asked a caregiver to assist with turning Ms A, and recorded that hardened skin had formed on Ms A's buttock, and her lower and upper extremities were pale. A capillary nail refill test[22] was performed on her lower and upper nails, taking six seconds for colour to return. It was also recorded that Ms A was not opening her mouth for mouth care using a swab. Ms A declined sips of water.

101. At 6.20am RN J documented in the progress notes the further checks she had undertaken:

> "At 0310 hours, turned [Ms A], mouth cares done using warm water and swab. Settled to sleep afterward. Regularly checked. At 0600 hours, noticed she's awake … cares done … and turned … noticed that the colour on the hardened skin on … buttock turned light bluish, its about 18cm in diameter … wound size still the same but there's presence

[21] Softened or broken down.

[22] The "capillary nail refill test" is a test done on the nail beds to monitor dehydration and the amount of blood flow to tissue. If there is good blood flow to the nail bed, a pink colour should return in less than two seconds after pressure is removed.

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of very foul smell, exudate is yellowish in colour, moderate in amount on the old dressing …"

102. RN J updated the evaluation chart, noting deterioration with 30% necrotic tissue, macerated margins, no pain but a moderate amount of odorous yellow exudate.

103. RN D told HDC that at around 9am, with the help of a caregiver she assisted Ms A to a shower chair. RN D said:

> "It was during the time we were attending to her hygiene cares that I observed that [Ms A] was very unwell … she just nodded or shook her head … we checked her observations and noted her temperature was high. Her [blood sugar level] (19.1) remained high even after her morning dose of insulin … Her skin looked possibly jaundiced so I thought she had developed septicaemia."

104. The caregiver told HDC that she did not feel "right about showering [Ms A]" because Ms A looked pale. The caregiver said: "I voiced my concerns only to be told it was a while ago [that Ms A] had a shower."

105. RN D said that she had been asked by RN C to get Ms A up for a shower, which she now realises was not appropriate given her condition. RN D asked a registered nurse to re-do the dressing on Ms A's pressure wound while she went to see the Facility Manager, Mr G, to discuss her observations of Ms A and her plan to request a GP visit, which Mr G agreed with.

106. At 11am RN C was informed of Ms A's condition and went to see her. RN C later noted that she spoke to Ms A, but Ms A did not respond. RN C recorded that she directed that the GP be contacted and that Ms A's observations and neurological observations be taken.

107. At 1.10pm RN K recorded Ms A's vital signs on a Neurological Observation Sheet. She was non-responsive with a temperature of around 38.9ºC, oxygen saturation 93%, pulse 49 beats per minute, blood pressure (BP) 80/50mmHg, and respiratory rate (RR) 45 breaths per minute.

108. At 1.20pm RN D faxed the medical centre requesting a review by the on-call GP. Under the heading "Presenting Problems", RN D wrote: "[Ms A's] condition has greatly deteriorated, especially today. She is not conversing and she is not taking anything orally even her medications but still consenting to insulin. She is also experiencing lots of muscle spasms." RN D recorded in the fax Ms A's vital signs and that she had a grade 2 pressure sore.[23] RN D telephoned the medical centre after sending the fax, to check whether it had been seen, and was told that it had been forwarded to the on-call GP.[24]

109. At 1.25pm RN D recorded in the progress notes that Ms A was "non-responsive", not taking her oral medications, and not reacting to pain stimuli, and that her wound was now looking

[23] Grade 2 refers to partial-thickness skin loss involving the epidermis (outer layer of the skin) and/or the dermis (second layer of the skin), and presents as an abrasion or clear blister.

[24] RN D told HDC that the fax and (first) follow-up call was about mid-morning; however, the fax is recorded as having been sent at 1.20pm.

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"necrotic". The notes record that RN D contacted Ms A's sister to advise her of Ms A's condition and that the "prognosis might be poor".

110. Ms A's observations were recorded again at 2.45pm, by which time her respiratory rate had decreased to around 42.

111. RN D told HDC that she telephoned the medical centre again following up on the fax, and "the nurse said they still knew there was a house call to be made".[25] At 3pm RN D recorded: "[T]he RN said the Doctors are having a discussion on how to manage [Ms A], she will ring us." At 3.15pm, notes record that the medical centre advised by telephone to transport Ms A to hospital, and therefore an ambulance was called. The ambulance arrived at the facility at 3.20pm. IV fluids were commenced and, at 3.45pm, Ms A was transferred to Hospital 1.

Admission to hospital

112. That evening, Ms A was transferred from Hospital 1 to Hospital 2, owing to a presumed diagnosis of sepsis secondary to the sacral pressure wound. In the early hours of the following morning, Ms A underwent surgical debridement. Postoperatively she was managed in the intensive care unit but, despite maximum inotropic support[26] and ventilation, her condition became unsupportable. Ms A died on 24 Month7.

Zopiclone administration

113. Prior to her transfer to the facility in Month1, Ms A had been prescribed zopiclone 7.5mg at night (9pm) for insomnia.[27] She remained on this prescription during the events in issue. On 1 Month5, Dr E also charted extra zopiclone: one to two tablets at night PRN for insomnia. Ms A had requested extra zopiclone as she was having difficulty getting to sleep with one tablet, and sometimes was waking between 1am and 3am, in part because of her sore shoulder. At the same time, Dr E charted ibuprofen 200mg three times a day PRN with food for her shoulder pain, and asked for physiotherapist review.

114. During Month5 and Month6, at Ms A's request, zopiclone PRN was administered to her on numerous occasions after 2am, and sometimes as late as 6.10am.[28] Dr E reviewed Ms A's medication chart on 5 Month6. He told HDC that his usual practice when undertaking a medication review of a patient in residential care includes reviewing and taking a history from the patient; examining the patient and reviewing the past notes; and reviewing the prescription chart and enquiring of nursing staff if there has been any issue regarding the prescribed medication or regarding the use of PRN medications.

115. With regard to the 5 Month6 medication review for Ms A, Dr E said that he can no longer recall whether he reviewed the medication dispensing page at the time, but would have asked the nursing staff about the PRN medications and Ms A's sleep, in accordance with his usual practice. Further, Dr E stated:

> "I recall that I was advised that [Ms A] often stayed up watching TV late into the night or would often wake between 1am–3am, requesting a further zopiclone tablet if she

[25] RN D told HDC that this (second) call was around midday; however, as noted, the fax was sent at 1.20pm.
[26] Stabilisation of circulation and oxygen supply.
[27] Although charted for 9pm, Ms A's Care Plan stated that she preferred to take it at 10pm.
[28] As recorded on the Non-packed or PRN Administration Record.

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could not get back to sleep. I recall being told that she was typically taking the second tablet between midnight and 3am and on occasions in the morning if she had not slept all night. I advised I was not in favour of this and that she should be encouraged not to watch TV late into the night and should in general not be given a tablet in the morning unless she had not slept that night. I did not alter my prescription of the second dose being 'nocte'."

116. During Month7, at Ms A's request, zopiclone PRN continued to be administered to her as follows:

Date	Time	RN	Recorded in Manager's Report
6 Month7	5.20am	RN B	Y
7 Month7	2am	RN B	Y
8 Month7	4am	RN K	Y
9 Month7	2am	RN B	Y
10 Month7	3am	RN B	N
11 Month7	6.30am	RN B	Y
12 Month7	5.50am	RN D	Y
15 Month7	6am	RN L	Y
20 Month7	4.30am	RN K	Y
21 Month7	2pm	RN B	N

117. As is shown, on eight of the ten occasions during Month7 on which PRN zopiclone was administered to Ms A, this was documented in the Manager's Report, including the time of administration. The book was reviewed and signed by both the Facility Manager and the Clinical Manager following each 24-hour period.

118. Following the 3am administration on 10 Month7 at 1.45pm, a caregiver recorded: "[Ms A] very sleepy after her 'big' day yesterday, small meals taken, fluid intake good, turns met on request …"

119. As noted, RN D recorded the 5.50am administration on 12 Month7 in the Manager's Report. At 2.30pm that day, RN K recorded in the progress notes that Ms A was "too sleepy to eat her lunch", and that this was because she had had her sleeping tablets at 5.50am. It was also recorded in the Manager's Report for the morning shift: "[Ms A]: very sleepy during the day — no concerns."

120. Following the 6am administration on 15 Month7, a caregiver recorded: "A very quiet shift for [Ms A] — dozing most of the day, usual breakfast given but not eaten — didn't eat her lunch …"

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121. RN B said that she did not address Ms A's requests for zopiclone at the multi-disciplinary review meeting on 16 Month7, as this seemed to have been an accepted practice in the management of Ms A's care over the previous two months. In response to my provisional decision, RN B told HDC:

> "[I]n [Ms A's] case she ha[d] no [enduring power of attorney] and she was making her decisions. I queried about her practice to take her Zopiclone (sleeping tablet) in the early hours of the morning to senior nurses, they said she [has] been doing this for some time and everyone is giving otherwise [Ms A] won't agree. I know I should have questioned but as a new nurse I was unable."

122. At 6.45am on 21 Month7, RN K recorded in the progress notes that Ms A seemed to be hallucinating visually. RN K noted: "[S]he also asked for … Zopiclone (7.5mg) at 0600 hrs. Explained her the time and she agreed." Zopiclone was not administered that morning but, as noted, was given at 2 o'clock that afternoon.

Statements from staff regarding sacral pressure wound management

123. Bupa accepts that "at each point when a change in the [sacral pressure] wound was identified, decisions regarding changes to the dressing plan should have been considered and acted on". Bupa said that the nurses believed their role was to inform the Clinical Manager or Unit Coordinator, who would arrange any necessary follow-up.

124. Bupa further told HDC:

> "[Bupa] understand[s] that although all qualified staff were able to arrange a GP review or referral to allied health, historically this was frequently completed by the UC or CM, hence their lack of follow through …
>
> The RNs now understand that it is their responsibility to do this and each of the RNs working at the facility have confirmed that they now request reviews and arrange referrals to allied health whilst keeping the CM or [Facility] Manager informed."

125. RN C referred to the turn chart, and noted: "[Ms A] was adamant, despite the GP, RNs, the unit co-ordinator and myself talking to her about the importance of turning, that she wasn't to be turned overnight."

126. RN C acknowledged that Ms A should have been seen by the GP sooner than she was, and that wound specialist advice should have been sought. RN C stated:

> "If I had been informed of her overall condition, or concerns with any part of her condition, I would have asked for the nursing staff to ask/or asked the GP myself to review her around the time of the multi-disciplinary review. Any changes to a resident's general condition, or concerns should be addressed as soon as possible and good communication between staff is important so this can occur."

127. RN D acknowledged to HDC that the pressure wound was deteriorating and she should have changed the wound management plan on 10 Month7 when she noted that the wound was not improving with the current plan. Further, she acknowledged that she could have

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arranged for GP review or referral to a wound specialist nurse and dietary assistance even though it was "hard to convince [Ms A]". RN D also noted:

> "As I was the one who was in direct contact with [Ms A], I shouldn't have got her up for the shower, even though the CM had said that she wanted us to shower her and sit her in the chair in the lounge. I realise that after seeing her condition I should have used my professional judgement and arranged for her to be assessed immediately and transferred to the hospital for further management instead of calling for a house visit by the on call GP."

128. RN B told HDC: "As a new staff member inexperienced in aged care, I expected any decision regarding getting medical advice about [Ms A's] wound or her [blood sugar levels] would be made by senior staff or management …"

129. RN B said she accepts that she should have included more detail about Ms A's pressure injury in the MDR documentation. She had reviewed the notes and, as the injury was "not very good" at this time, she addressed this in the meeting by looking at wound management.

130. RN B also noted that RN D was present on the doctor's rounds one day a week, and from time to time got handover when rostered on a shift. RN B stated:

> "Prior to [Ms A's] case, the practice was that the Unit Co-ordinator was responsible for doing doctor's referrals (except in an emergency situation where we would ring 111 …). This has now changed …"

131. While she acknowledged that on 21 Month7 she knew that the wound was infected, RN B said that she did not appreciate at the time that it could become septicaemic so quickly:

> "In hindsight and with my increased knowledge of wound management and infection that I now have as a result of this experience, I agree that further medical advice should have been sought prior to 21 [Month7] …
>
> I am very upset by what happened to [Ms A], and there are many lessons that have been learnt from this terrible situation …
>
> If I had have known then what I know now about wound care and infection, [Ms A's] care would definitely have been managed differently. I would have sent her to hospital sooner and referred her straightaway rather than waiting for someone else to take action."

132. RN J stated to HDC:

> "In hindsight, I accept that when I observed [Ms A's] wound on 17 [Month7] that I should have spoken to the Clinical Manager about why a wound specialist had not been called. As I was usually on afternoon shift during this time, starting at 3pm, I rarely had personal contact with the Clinical Nurse Manager but in hindsight, I should have left her a note or emailed her my concerns. I also accept I should have asked for a review by the GP for [Ms A's] deteriorating condition from 18 [Month7]."

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133. RN K told HDC that, with the benefit of hindsight, she regrets that she did not wake Ms A to take observations on 21 Month7, and acknowledges that this may have then prompted her to obtain after-hours medical advice.

Statements from staff regarding nutrition

134. Bupa told HDC that it acknowledges that "the scores [in documentation] related to nutrition were inaccurate and should have been scored lower than those documented". RN B also acknowledged the discrepancies in the nutrition assessment compared with the score indicated in the Braden assessment.

135. Bupa further said:

> "The nursing staff acknowledge that it may have been appropriate to consider a referral to a dietician when the pressure area was first identified and also that when her appetite decreased further and the wound continued to deteriorate despite regular wound dressings, relevant referrals to a dietician or the GP should have been made."

Statements regarding administration of PRN zopiclone

136. As noted, Ms A had been prescribed zopiclone at night for insomnia prior to her transfer to the facility in Month1. From 1 Month5, Dr E prescribed additional zopiclone PRN, together with ibuprofen, for Ms A's sore shoulder.

137. With regard to the administration of zopiclone, Dr E acknowledged that having reviewed Ms A's medication chart, the charting of zopiclone was "somewhat ambiguous". Further, he said that the PRN zopiclone should have been charted as zopiclone 7.5mg nocte in addition to the regular dose if required.

138. Dr E told HDC that his intention was for zopiclone 7.5mg to be administered between 9pm and 11pm, and a further 7.5mg dose only if required later in the evening or before 3am. Further, he said that he became aware that at times Ms A was requesting and being given the second dose in the morning (after 3am) if she had not slept. He considered that practice, while not routine and while he did not want it to be a regular pattern, reasonable in the circumstances:

> "[Ms A] conversed well, was competent and had her own opinions on what she did and did not want for her treatment. This often brought a degree of tension between her, the nursing staff, and me … The nursing staff involved with [Ms A's] care, I think found [Ms A's quite specific views on the medications and care she did or did not want] difficult. The nurses always showed concern, dedication and adequate skill in caring for [Ms A] from my experience."

139. In response to my provisional opinion, Dr E stated: "[O]n reflection I accept that my advice to staff was ambiguous regarding the continued administration of zopiclone to [Ms A]. I cannot now recall if I specifically advised nursing staff not to administer zopiclone to [Ms A] after 3am."

140. Bupa acknowledged that giving zopiclone in the early hours of the morning is not good practice. However, it said: "[T]his was a decision that was made by a young and competent person and it appears that [Ms A] had been used to having extra zopiclone without any

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significant daytime drowsiness … It is possible that the observed drowsiness later in [Ms A's] care was acute illness aggravated by the late administration of the sedative."

141. RN C told HDC:

> "I recall from nursing staff, [Ms A] declined to take two sleeping tablets at the time she settled for bed, and wanted to have one for later in the night/early morning to take to get more hours of sleep altogether."

142. RN C understood that this was a longstanding practice. She stated:

> "I wasn't aware that this medication was being given by the nursing staff in the early hours of the morning; I wouldn't have thought that staff would give any sleeping tablets after 0100 in the morning due to affect. I can only say that because I wouldn't practice in this manner, I really didn't think staff would be doing this and didn't ask about their routine."

143. In her response to HDC, RN D recalled that when Dr E charted the PRN dose, it was suggested that it would be given with her regular dose, but Ms A did not want this as she wanted to have more control over when it was given. RN D noted: "[Ms A] was a client who was very strong willed and aware of what she wanted and had no hesitation in letting staff know … If staff refused to do what she wanted she would perform and cry and sob endlessly."

144. With regard to the administration of zopiclone at 5.50am on 12 Month7, RN D told HDC: "I acknowledge that I should have followed my instincts and professional knowledge regarding safe management and administration of medications and not administered a sleeping tablet at that time of the morning."

145. RN B worked predominantly night duty shifts during Month7. She told HDC that she remembers the first time that Ms A asked her for zopiclone in the morning hours. RN B said:

> "I refused to give it to her. She became very agitated, kept ringing the bell and demanding to have it. She said that the Doctor had charted for her to have it 'as requested'. I asked one of the senior nurses what to do, and was told that she is allowed to have it as needed. This is correct, the doctor had charted her Zopiclone PRN nocte, which means that we can give it as needed. [Ms A] had been prescribed regular zopiclone at night and also extra as needed."

146. RN B said that she did not address Ms A's requests for zopiclone at the MDR meeting on 16 Month7 as this seemed to have been an accepted practice in the management of Ms A's care over the previous two months.

147. RN B also told HDC:

> "I accept that administering zopiclone in the early morning hours is not the norm and can see how this could affect [Ms A's] behaviour during the day. As a new staff member (and relatively inexperienced) I thought that this practice was appropriate as senior staff, management and the doctor were all aware of it and it was what had been charted."

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148. RN K said:

> "[I] and the other registered nurses would remind [Ms A] that taking sleeping tablets [in the early hours of the morning] could result in drowsiness and difficulty carrying out the cares during the day. But, [Ms A's] response was that it is charted for her 'PRN' so she was entitled to have it when she asked for it."

149. RN K said that she "believed that it was [Ms A's] choice ultimately as to whether and when she could have the Zopiclone as the medication had been charted 'PRN' and [Ms A] had the ability to make her own decisions".

150. RN K told HDC that she did not raise this with Dr E, as she believed that the issue would/should be raised either by her primary nurse (RN B) or the Unit Coordinator (RN D), who generally accompanied Dr E on his rounds.

151. RN K further said that she was aware that Dr E carried out a regular medication review, which would include consideration of the use of PRN medications charted. In addition, she said that RN C was also aware of Ms A's requests for zopiclone, as she (RN K) always documented the PRN medication details in the Facility Manager's report.

Bupa's relevant policies

152. Bupa's policy entitled "Wounds — Management of" in place at the time of these events stated:

> "… Clinical Managers are responsible for providing clinical leadership and oversight to ensure best practice wound management …
>
> **Wound healing**
>
> - The rate of healing of a wound varies depending on the resident's general health, location of the wound, degree of damage and the treatment applied, and nutritional status
> - When treating the wound it is necessary to consider all factors that may delay the healing process and, where possible, minimise them
>
> **Wound management plan**
>
> - The wound management plan is developed by a Registered Nurse following the wound assessment, and documented on the Wound Management plan
> - The RN is required to clearly state the goal for the wound, and the plan
> - **At subsequent dressing changes, nurses must continue with the intended wound management plan, unless a change is clinically indicated and the reason for this is clearly stated**
>
> **Care planning**
>
> - A short term care plan is developed for wounds that are expected to heal within 6 weeks …

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Evaluation of wounds

- There will be regular ongoing assessment and evaluation of the status of the wound and the effectiveness of the current wound management plan.
- This will occur at **each** dressing change and recorded on the Wound evaluation form
- If a wound appears infected, obtain a wound swab for culture and sensitivity and notify the doctor

Accessing specialist advice

- Registered nurses are responsible for completing referral for specialist advice which is readily available through appropriate channels (see below)
- Referrals should occur promptly if there is little evidence of improvement in a wound, where interventions appear not to be achieving the desired healing outcome or:
  - Whenever there is rapid deterioration
  - Complex or non healing wounds …"

Subsequent events

Bupa response

153. Bupa stated that it acknowledges that the care provided to Ms A in Month7 was of a less than optimal standard, and that it deeply regrets this. Bupa identified that from discussions with staff, and documentation:

> "… it appears that staff have focused on [Ms A's] social issues as the cause of her decreased appetite and low mood. We believe that this was a major contributing factor in staff not recognising and acting on the generalised decline in her condition."

154. Bupa instigated an internal review following Ms A's death, which it acknowledged identified "gaps in communication and planning of care". It reported a number of practice changes and remedial actions as a result of this incident, including:

a) Improved managerial oversight through daily and weekly meetings, including review of residents with current wounds.

b) Nursing handover changes including a bedside/visual check of all residents assessed as unwell.

c) Education and coaching on wound care, effective clinical communication,[29] role and responsibilities, nutrition and hydration, and the learnings from the internal investigation into Ms A's care.

155. Bupa has continued to advise HDC of further corrective actions and initiatives including:

a) Review of the senior clinical team at the facility. It was determined there was a blurring of responsibilities between the Unit Coordinator role and the Clinical Manager role.

[29] By introduction at the facility of ISBAR, an internationally recognised communication tool providing a framework for clinical conversations between health professionals.

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Following the current Unit Coordinator transferring to another Bupa facility, her role was disestablished, and coordination responsibility of the hospital unit devolved to the Clinical Manager.

b) A new Clinical Manager has been recruited and has fully completed orientation at the facility, with additional mentoring over a period of months from an experienced registered nurse relief Care Home Manager.

c) Regular follow-up clinical and care home audits have been conducted at the facility by Bupa's Operations Manager and senior members of the Nursing, Quality and Risk team.

d) Review and release of Bupa's Pressure Injury Prevention and Management policy, including clearer guidance on classification, prevention, assessment, and management of injuries. The policy also references a change in practice for reporting serious injuries to HealthCERT, and specifies expected timeframes for healing, and guidance on action and escalation where healing is delayed.

e) Review of Bupa's education plan and policy.

f) Review of the multi-disciplinary review (renamed resident review) policy, including prompts for GPs and nurses to review usage of PRN (as required) medications on the review checklist, discussion/documentation of discussion of frequency of PRN medication usage, and healing progress of any current wound.

g) Commencement of a Clinical Manager Project, and development of a Clinical Manager Framework and Clinical Manager Orientation Programme.

h) Creation of a Clinical Manager leadership programme for completion by all Clinical Managers within two years in five cohort groups.

i) Implementation of an electronic medication management system across all Bupa care homes, with all care homes due to be transitioned by December 2016.

j) Implementation of an electronic incident management system across Bupa care homes, due for pilot in early 2017, and full rollout in all care homes commencing mid-2017.

k) Employment of three senior nurses with capacity to fulfil relief Care Home and/or Clinical Manager roles due to any leave or vacancies.

l) A proposed new role of "roving Clinical Manager" for Bupa facilities, to assist with orientation of new Clinical Managers at facilities.

RN C's response

156. RN C advised HDC:

> "I am no longer working at [the facility] as I felt during my time there unsupported by management in my own practice, in trying to ensure effective changes so what happened to [Ms A] didn't occur again and in getting nursing staff to use their full assessment skills and clinical judgement to provide optimum care."

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157. While RN C is no longer in a clinical management role, she said that she would "always take away from my experience working at [the facility] and with Ms A's death the following:

> "Not to assume that the staff working with/beneath me are communicating everything I should hear effectively to me and others in the multi-disciplinary team.
>
> While it isn't always easy, not let myself be put in a position, where I don't feel supported, feel overwhelmed or be left on my own when I don't feel I'm ready.
>
> Always ask questions, don't leave it to others to tell me what I need to hear. Actively seek information from staff I am working with.
>
> Encourage staff I am working with to proactively pursue referrals and involve all members of the multi-disciplinary team if there's any doubt regarding a patients care or condition, regardless of what policies may indicate. Always put the patient first and encourage others I work with to do the same.
>
> Document everything, every input that I have and encourage others I work with to do so too, no matter what …
>
> Ensure in future I get a good orientation and 'grounding' in future jobs, so I am familiar with all aspects of the job I am required to do."

RN D's response

158. RN D said:

> "I realise that I should have called for an ambulance [on 23 Month7] as [Ms A's] condition warranted hospitalisation. I apologise for not doing so.
>
> This has been a learning incident for me and this has made me become more vigilant and I now ensure that I get to see residents everyday, especially those with complex medical conditions and those who have been reported to be unwell, to assess them and act accordingly. I have managed to refer many residents for wound specialist assessment and dietician advice and this has had a positive impact on my role. I have been giving support to my colleague RNs to have confidence in their roles as RNs/UCs."

159. In her further response to HDC, RN D said:

> "On reflecting on this case I have noted that I ought to have been more proactive and used my own professional judgement as an RN in these matters. I should not have been so influenced by the wishes of the patient when I thought that they were not best practice … I have vowed to ensure that residents are referred … in a timely manner and I am asking [for] review … even earlier if the first advice seems not to be working. I have advised my colleague RNs to be able to do the same, and to assess residents thoroughly and act and refer appropriately …
>
> I also accept and acknowledge that as soon as I discover that a resident is not well I need to use my own critical judgement and not to rely on someone else …

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During the [time] I worked at the facility I was told many times by people that I had overreacted but this always proved to be necessary and I really don't know what hindered me from doing the same this time. One will never be penalised for over reacting but will be penalised for being too slow to act. I have learned a big lesson following my involvement in this case … I am passionate about my work as a registered nurse and I apologise for the lapses in care provided to [Ms A] that occurred as a result of anything I did or failed to do as I always try to provide care with the best interests of my patients at the centre of all I do."

RN B's response

160. As noted above, RN B reflected on the lessons she has learnt from this incident. She advised HDC:

> "I have received education from [manufacturers of wound care products] on wound care and am now the wound nurse at the facility. I am also the infection control officer, having completed online education through the DHB on infection and wound care. I now have a much greater knowledge on wound care and infection which I trust will be extremely useful in preventing this type of situation occurring again."

161. RN B also outlined many of the procedural changes that have been adopted by Bupa to improve communication and handover processes, as well as wound care management. She confirmed that "[i]f any nurse considers a patient needs to see a doctor we are able to put it in the diary (whereas previously the decision on who needs to see the doctor was up to the Unit Co-ordinator)".

Nursing Council of New Zealand

162. During this investigation, the Nursing Council of New Zealand made enquiries into RN C's, RN D's and RN B's competence to practise.

Responses to provisional report

163. Ms A's family provided a response to the "information gathered" section of my provisional opinion, and reiterated their concerns about the care provided to Ms A.

164. Bupa provided a response to my provisional opinion. It stated that it "accepts the finding that the level of care provided to [Ms A] at the facility did not meet the expected standard of care required for a younger resident with chronic medical conditions and complex comorbidities. Bupa deeply regrets this, and accepts responsibility for these failures".

165. RN C was provided with an opportunity to respond to my provisional opinion, and she advised that she had no further comments to make.

166. RN D provided a response to my provisional opinion. She stated that she has nothing more to add to the information she has provided previously. She is very remorseful that the care provided to Ms A was not of the required standard and apologised for her part in that. RN D also provided HDC with a copy of her training and education in aged care from February 2015.

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167. RN B provided a response to my provisional opinion, and it has been incorporated where appropriate. She stated: "My sincere apology to [Ms A's] family about what had happened knowingly or unknowingly …"

168. RN J provided a response to my provisional opinion. She apologised for her part in the failings in the care provided to Ms A.

169. RN K provided a response to my provisional opinion. Her response has been incorporated where appropriate.

170. Dr E provided a response to my provisional opinion, and it has been incorporated where appropriate. He stated that "overall … the comments made are fair". He said that since this incident, he has reflected on his practice of prescribing zopiclone. He ensures that his instructions are more "prescriptive, direct and clear to patients and staff administering the prescription".

Relevant standards

171. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.7 Deliver care based on best available evidence and best practice.
>
> …
>
> 4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.
>
> …
>
> 4.10 Practice in accordance with professional standards relating to safety and quality health care."

Opinion: introduction

172. Ms A— a hospital-level resident at the facility suffering debilitating multiple sclerosis and bed bound with insulin dependent diabetes — was at moderate risk of suffering a pressure injury.

173. This report considers the care Ms A received during Month7 after she developed a sacral pressure wound discovered on 2 Month7. From that date, staff at the hospital commenced a wound care plan, which was documented.

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174. On 9 Month7 Ms A was seen by the visiting GP, Dr E, who assessed the injury as superficial and likely to respond to nursing care. From later that evening, however, the pressure wound began to deteriorate.

175. Three interrelated issues appear to have affected the care Ms A received: the nature of her wound management, the administration of zopiclone PRN, and her nutritional status.

176. Over the period from the evening of 9 Month7 to 23 Month7, staff recorded the continuing deterioration of the sacral pressure wound on the wound evaluation chart and in the progress notes and, on 15 Month7, in the Manager's Report.

177. On 16 Month7, a multi-disciplinary review meeting was held, at which Ms A's wound was noted but no action taken to seek further medical review or to change the wound management plan. From about that time onwards, Ms A's general condition, including her appetite, was also noted to be deteriorating, again without medical review being sought.

178. Staff continued to administer zopiclone PRN during Month7 and, between 6 and 21 Month7, Ms A was given the medication on 10 occasions, frequently between 4am and 6.30am and, on one occasion, at 2pm.

Opinion: Bupa Care Services NZ Limited — breach

179. In accordance with the Code, Bupa has a responsibility to operate the facility in a manner that provides its residents with services of an appropriate standard. The New Zealand Health and Disability Sector Standards (NZHDSS) also require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.[30]

180. As set out above, staff at the facility individually and as a team failed to act on observations of Ms A's deteriorating sacral pressure wound and her deteriorating overall condition. I am concerned at the lack of critical thinking by staff in this respect. Bupa acknowledges that had a medical review of Ms A been made earlier, a hospital admission may have been avoided. This case highlights the importance of aged residential care facilities having staff with adequate expertise and skill to support younger residents with chronic medical conditions and complex comorbidities. In such circumstances, medical, nursing, and support staff need to be alert to the resident's changing health status. Staff must assess, think critically, and respond appropriately to, deterioration in the resident's condition. In my view, the facility failed in its duty of care to Ms A in this regard at a critical time in her life.

Sacral pressure wound care

181. It is clear from the statements of staff that Ms A was an independent, assertive person who expressed her preferences for her care clearly and, at times, against the efforts of staff to assist in her care. It is also clear that staff were aware of, and endeavouring to assist with, her [social issues], which impacted on her general mood at the time of these events.

[30] New Zealand Health and Disability Sector (Core) Standards (NZS8134.1.12:2008, Standard 2.2).

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Unfortunately, it seems that this clouded their primary professional duty to Ms A in the face of the deterioration of her pressure wound and her general condition.

182. Bupa's policy entitled "Wounds — Management of" (the Policy) stated that registered nurses must continue with the intended Wound Management Plan unless a change is clinically indicated. There is to be regular ongoing assessment and evaluation of the status of the wound and the effectiveness of the Wound Management Plan. In addition, the Policy sets out the action to be taken if a wound appears infected, there is little evidence of improvement, or where interventions appear not to be achieving the desired healing outcome. Further, the Clinical Manager is responsible for providing clinical leadership and oversight to ensure best practice wound management. My expert nursing advisor, RN Carey, advised me that Bupa's policies and guidelines in Month7 were clinically appropriate and of a high standard, and I accept this advice. However, as set out below, I am concerned at the implementation of those policies by staff.

183. RN Carey advised that there were multiple and significant departures from accepted nursing standards in relation to wound care, including:

- Failures by RN C to follow up the wound care at the multi-disciplinary review and to action Ms A's unresponsive presentation appropriately on 23 Month7.
- Failures by RN D to instigate appropriate wound care measures in the deteriorating wound on 10 Month7 and, in the care provided on 23 Month7, in responding to Ms A's signs and symptoms.
- Failures by RN B to address wound care adequately at the MDR meeting, and to provide appropriate wound care on 21 Month7 to address the presence of non-viable necrotic tissue.
- Failures by several registered nurses to assess and action their observations of Ms A's deteriorating wound and general deterioration adequately, especially in the period 19–23 Month7.

184. Visits by the GP to the facility were made twice weekly, and nursing staff were aware that they were able to record a request for GP review in the diary. However, staff were reluctant to do so owing to their belief that this would be done by either the Clinical Manager or the Unit Coordinator, as had been the previous practice.

185. RN Carey is critical that, from 10 Month7, wound deterioration was noted by several staff but without corresponding change to the wound care plan and interventions. I am very concerned that staff failed to take the actions required by Bupa's Policy, in particular evaluating the effectiveness of the Wound Management Plan, notifying the GP if the wound appeared infected, and promptly referring for specialist advice given that there was not evidence of improvement in the wound. From 15 Month7, staff should have sought referral to a wound specialist nurse and/or GP review for Ms A's deteriorating sacral wound, as required by Bupa's Policy. I note that on that date the significant deterioration of the wound was clearly identified in the Manager's Report.

186. RN Carey considers that the MDR on 16 Month7 was a missed opportunity to review the use of PRN zopiclone. I agree, and consider that it also represented a further missed

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opportunity to consider the deteriorating wound, in light of the content of wound care documentation including the entry in the Manager's Report of 15 Month7.

187. I also accept RN Carey's advice that a GP review should have been sought on 18 Month7, given that Ms A was a diabetic immobile resident who had a deteriorating sacral pressure injury, and who was by then withdrawn, upset, and with a poor dietary intake.

188. As RN Carey observed, overall there was "a lack of appropriate assessment, critical thinking and action in response to [Ms] A's deteriorating condition". I am very concerned by, and critical of, the reluctance of nursing staff to act on their observations of Ms A beyond recording in the notes, handing over to the next shift and, on one occasion, recording observations of the deterioration of the wound in the Manager's Report. I consider that this represents a lack of critical thinking on the part of nursing staff, and was not consistent with Bupa's Policy or accepted nursing standards. I also note that this de facto practice had apparently established itself owing to the procedure of a previous Clinical Manager/Unit Coordinator.

189. In relation to Ms A's care from 20–22 Month7, I am critical of RN J, RN I, and RN K, who all noted Ms A's lack of responsiveness and various clinical symptoms, but did not carry out a complete assessment of Ms A or take appropriate action in response to her condition.

Administration of PRN zopiclone

190. I note that at Dr E's medication review in mid-Month6, the issue of the administration of PRN zopiclone was a matter he discussed with staff. However, I am critical that staff repeatedly continued to administer zopiclone PRN at inappropriate times without reference to Dr E, the prescriber, to seek advice. The records demonstrate that the inappropriate administration of zopiclone impacted on Ms A's daytime wakefulness in the critical period, and therefore upon her nutritional intake.

Conclusion

191. As previously stated by this Office:[31]

> "The inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that did not sufficiently support and assist staff to do what was required of them. [The rest home] as an organisation must bear overall responsibility for this."

192. In my view, Bupa had the ultimate responsibility to ensure that Ms A received care that was of an appropriate standard and complied with the Code. In my view, for the reasons outlined above, Bupa failed in that responsibility and breached Right 4(1) of the Code.

Other comment

Dietary management

193. RN Carey also advised that more should have been done to ensure that Ms A was consuming an adequate amount of protein once she had developed a pressure injury. I agree, but consider that this aspect was not without some difficulty given that Ms A's strong views

[31] 09HDC01783 and 11HDC00686.

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were well established and known to the GP and to nursing staff and, at times, were in conflict with the medical advice provided to her.

Orientation of Clinical Manager

194. The orientation of the new Clinical Manager, RN C, should have included a "follow-up" meeting that would have fallen within the period of these events. The Facility Manager, Mr G, who should have facilitated this, was new to the organisation and orientating himself. He was also absent on leave for a period during this time. I note the conflict in evidence as to whether he was on leave during the lead-up to Ms A's death or following it;[32] however, it is unnecessary for me to make a factual finding in that regard, as it is not disputed that a follow-up orientation meeting did not take place. I accept the advice of my in-house nursing advisor, RN Dawn Carey, that such a meeting to capture progress and concern is essential, especially for senior roles, and am critical that no such meeting was offered.

Opinion: RN C — breach

195. RN C was the Clinical Manager at the facility and had responsibility for providing clinical leadership and support to clinical and care staff. In Month7, she was very new in the role. She reports feeling "very overwhelmed" in the role, and that her concerns about being on her own early on were "brushed aside" by management. She stated that these concerns were in relation to a period when the new Facility Manager, Mr G, was on holiday during Month7. As noted above,[33] it is unnecessary for me to make a factual finding regarding when Mr G was on leave, as it is not disputed that a follow-up orientation meeting did not take place.

Sacral pressure wound management

196. Bupa's policy entitled "Wounds — Management of" (the Policy) stated that the Clinical Manager is responsible for providing clinical leadership and oversight to ensure best practice wound management.

197. RN C was involved in a conversation with Ms A on 3 Month7 regarding the necessary interventions to prevent the breakdown of the sacral pressure wound, at which time Ms A expressed her preference not to be turned during the night if asleep, and (at that stage) declined the use of an air mattress notwithstanding the clinical advice that it was appropriate.

198. Ms A's sacral pressure wound began to deteriorate from the evening of 9 Month7 onwards. The primary record of the deterioration of the wound appears in the wound evaluation records and the progress notes; however, on 15 Month7 RN I clearly described a significant deterioration within the Manager's Record, the book reviewed and signed off daily by RN C as part of her duties.

[32] At paragraphs 36 and 37, above.
[33] At paragraph 185; see also paragraphs 36 and 37, above.

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199. The following day, RN C took part in the MDR, with RN B and others. Although there was reference to the pressure wound, no other concerns were raised or followed up regarding its management. RN Carey commented:

> "In my opinion, the presence of a sacral pressure injury in a diabetic, bed/wheelchair bound resident who has reluctantly accepted an air mattress and refuses to reposition overnight equates to a concerning combination. I consider that any experienced RN would share such concern. If that RN was in a managerial role I would expect them to question the reporting RN accordingly and/or review the wound care documentation. I note that [RN C] reports subsequently being informed that [Ms A] was not eating but not being aware that she also had a deteriorating pressure injury at this time. While I can appreciate that the nurses may not have consistently communicated concerns effectively to [RN C], I hold the opinion that as a CM, the responsibility lay with her to clarify and check. In my opinion, clinical oversight and leadership are integral parts of any clinical managerial role."

200. I agree with that advice. I note the entry in the Manager's Report the previous day, 15 Month7, which in my view represented a red flag on this issue. Further, entries within the Manager's Report from 17 Month7 onwards refer to Ms A's continuing general deterioration. For these reasons, I am critical that RN C did not follow up the issue of wound care management from 16 Month7, given the actions required by the Policy. I also agree with RN Carey's view that a GP review should have been sought from 18 Month7, owing to Ms A's presentation as a diabetic immobile resident with a deteriorating sacral pressure wound, who was noted to be withdrawn, upset, and with a poor dietary intake (also required by the Policy).

23 Month7

201. On 23 Month7, RN C was alerted to the acute condition of Ms A, and spoke to her at 11am. RN C noted that Ms A was unresponsive, and directed that the GP be contacted, and that Ms A's vital signs be taken. However, this was not done until after 1pm, for inclusion in the fax to the medical centre. RN Carey advised me that Ms A's observations taken at 1.10pm and 2.45pm indicate coma and sepsis.

202. RN Carey advised:

> "I have concerns that [RN C] would review [Ms A] at 11am and not realize that she was significantly unwell and in need of hospital level care. In my opinion, [RN C's] response to [Ms A's] unresponsive presentation was inappropriate and inadequate. I am critical that this response came from a RN and especially one in a clinical managerial position. In my opinion, [RN C] failed to appropriately assess, think or act in accordance with professional nursing and health standards."

203. I am critical of RN C's lack of response to Ms A's clear deterioration on 23 Month7, and I consider this to be poor care.

Zopiclone PRN administration

204. In light of the entries in the Manager's Report throughout Month7 I also find that RN C was given information on the regular inappropriate administration of zopiclone in the morning hours. Given her clinical leadership role, I am critical that she did not take steps to ensure

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that this was reviewed by the GP. However, my criticism is partially mitigated by the fact of the early Month6 medication review by Dr E, by which time an established pattern of late administration of zopiclone was shown within the PRN Administration Record.

205. Given her role to provide clinical leadership and support to clinical and care staff, the red flags that were raised in the documentation, albeit not consistently, and her personal contact with Ms A at 11am on 23 Month7, I find that RN C failed to provide services with reasonable care and skill to Ms A in Month7 in relation to wound assessment and the management and administration of zopiclone PRN. Accordingly, I find that RN C breached Right 4(1) of the Code.

Opinion: RN D — breach

206. RN D was the Unit Coordinator of the facility, and a registered nurse. Her responsibilities included co-ordinating the GP rounds and accompanying the visiting GP on them.

Sacral pressure wound care 9 and 10 Month7

207. RN D was present on 9 Month7 when Dr E reviewed Ms A's pressure injury during the morning shift. Following this, the dressing was not renewed for several hours, until the night shift.

208. In RN Carey's view, RN D retained professional accountability for ensuring that the dressing was renewed in a clinically appropriate timescale, in accordance with Nursing Council guidelines.[34] I agree, and am critical that she did not do so. I note that the first deterioration in the pressure wound was recorded that night.

209. I find, in accordance with RN Carey's advice, that a further opportunity for RN D to change the wound management plan presented itself the following day, 10 Month7, when for the first time necrotic tissue was noted. Despite this, the wound care plan and intervention remained unchanged. I am critical that RN D, as a registered nurse, would note deterioration in a wound bed and not take appropriate measures to address this, for example by application of a topical desloughing and debriding gel, or amend the wound care plan.

Zopiclone PRN administration

210. On 12 Month7, RN D gave Ms A zopiclone at 5.40am, after Ms A insisted that she wished to take the PRN medication. The subsequent day-shift notes record that Ms A was too sleepy to eat her lunch that day, and that she "fell" into sleep after breakfast, so her cares were not able to be maintained. RN Carey advised me:

> "[RN D] was a senior RN at [the facility] who regularly co-ordinated GP reviews and residents' MDRs. I am critical that [RN D] did not follow up on her experience on 12 [Month7] with appropriate action such as communication with the prescriber … I consider that [RN D] did not act in accordance with her professional responsibilities and

[34] Nursing Council of New Zealand (NCNZ) *Guideline: Direction and delegation* (Wellington: NCNZ, 2008).

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am moderately critical of her medication administration practice and lack of management in this regard."

211. Given her responsibility for co-ordinating GP reviews, RN D was in a better position than other staff to follow up her concerns. However, my criticism is partially mitigated by the fact of the entry she made on this day in the Manager's Report and the early Month6 medication review by Dr E, by which time an established pattern of late administration of zopiclone was shown within the PRN Administration Record.

23 Month7

212. On 23 Month7, RN D was directly involved with Ms A's care when she and a caregiver assisted her with a shower. At that time, RN D noted that Ms A was very unwell with no verbal responses. The observations she took were very concerning. Yet there was a delay of some hours while RN D consulted with the Facility Manager and RN C before she faxed the medical centre at 1.20pm.

213. RN Carey advised me:

> "I am critical of the delay in taking [Ms A's] vital signs and recognizing that she required comprehensive assessment … In my opinion, a fax to the GP was a completely inappropriate and inadequate response to the signs and symptoms that are recorded in the contemporaneous documentation and in [RN D's] statement. In my opinion, the care provided by [RN D] on 23 [Month7] was a significant departure from the accepted standards of nursing assessment and actions."

214. I accept this advice and am critical of RN D's care on 23 Month7.

215. For the above reasons, I find that RN D did not provide services to Ms A with reasonable care and skill. Accordingly, I find that RN D breached Right 4(1) of the Code.

Opinion: RN B — breach

216. RN B was Ms A's allocated nurse, and frequently worked a night shift during Month7. She was responsible for leading the MDR on 16 Month7.

217. During the night shift on 9 Month7, RN B re-dressed Ms A's pressure wound, several hours after the doctor had reviewed it in the early afternoon. She noted the wound's deterioration.

218. In the first three weeks of Month7, RN B administered zopiclone PRN to Ms A on six of the ten occasions it was given. On 21 Month7, RN B administered zopiclone at 2pm. On two of those occasions, including the 21st of Month7, RN B did not record the administration in the Manager's Report.[35] Ms A was regularly noted to be sleepy during the day following these occasions, and this compromised her ability to receive adequate nutrition and cares, including two-hourly turns.

[35] Although it was recorded on the Non-packed or PRN Administration Record on each occasion.

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219. In RN Carey's opinion, such administration was contrary to safe medication practices. Notwithstanding that Dr E had reviewed Ms A's medication on 5 Month6, I find that RN B was the nursing staff member most aware of the extent to which Ms A was requesting PRN zopiclone. In my view, RN B was best placed to identify the need for, and to seek, a medical review, and I am critical that she did not do so.

220. I also consider that the MDR led by RN B presented a lost opportunity to examine the inappropriate administration of PRN zopiclone.

221. At the MDR, RN B failed to highlight the wound's deterioration or to prompt an assessment of its management. RN Carey is critical of the lack of detail given by RN B concerning Ms A's pressure wound, especially in light of the wound documentation from the previous day, which noted significant changes. These included that Ms A was experiencing pain at the site — a new issue.

222. On 21 Month7, the day on which RN B administered zopiclone to Ms A on request at 2pm, RN B redressed the wound and noted that it had deteriorated further, but she did not change her care to address the presence of necrotic, non-viable tissue. Furthermore, staff on the previous shifts had noted that Ms A was experiencing visual hallucinations and appeared to be overdosed, as well as having poor liquid intake. RN Carey is strongly critical of RN B's administration of zopiclone at 2pm in those circumstances, and considers it to be a significant departure from nursing and medication standards.

223. Caregiver reports on 22 Month7 indicate that Ms A was declining turns and did not eat breakfast, but managed some ice cream at lunchtime. Her blood glucose levels were elevated. In those circumstances, RN Carey considers that RN B should have undertaken a comprehensive nursing assessment. RN Carey is very critical of the standard of nursing care that RN B provided to Ms A and, in her view, there were multiple moderate to significant departures from accepted standards of nursing.

224. I am very concerned at the poor care provided by RN B to Ms A, particularly given that RN B was Ms A's allocated nurse. I consider that RN B did not provide services to Ms A with reasonable care and skill during Month7. Accordingly, I find that she breached Right 4(1) of the Code.

Opinion: Dr E — adverse comment

225. On 9 Month7, when Dr E reviewed Ms A's sacral pressure wound, it was superficial and, in his opinion, should respond to good nursing care. As my expert adviser, Dr David Maplesden, observed, Dr E was not notified by nursing staff of the deterioration of the pressure wound and Ms A's general condition until the acute deterioration on 23 Month7.

226. Ms A's care following the development of the sacral pressure wound was compromised by the frequent administration of PRN zopiclone during the morning hours, and on one occasion in the afternoon, causing sleepiness and reduced appetite.

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227. Dr E said that he cannot recall whether he reviewed the medication dispensing page at the time of his review on 5 Month6, but recalled being told that typically Ms A was taking the tablet between midnight and 3am and, on occasion, in the morning if she had not slept all night. The Non-Packed or PRN Administration Record provided by Bupa shows that Ms A was given PRN zopiclone during Month5 on 11 occasions between 3am and 6am, and on six occasions during Month6.

228. Dr Maplesden advised that he would not expect a medication review to involve perusal of the drug administration charts provided staff were available to discuss any trends in PRN use.

229. Dr Maplesden further advised:

> "If [Dr E] had specifically advised against [Ms A's] use of zopiclone after 0300hrs, and noting the prescription instruction remained as 'nocte', I would expect nursing staff to have heeded these instructions and for [Dr E] to reasonably assume the instructions were being followed. I would be at least mildly critical if [Dr E] sanctioned the use of zopiclone after 0300hrs as this was likely to exacerbate [Ms A's] irregular sleep pattern and promote daytime drowsiness."

230. I note that Dr E advised the facility staff that he was not in favour of this pattern of administration of the second tablet, and that Ms A should be encouraged not to watch TV late into the night and should in general not be given a tablet in the morning unless she had not slept that night. I find that Dr E's advice to staff was ambiguous regarding the continued administration of zopiclone to Ms A in the morning, and I am concerned that it could be seen to have sanctioned the existing trend described by staff and shown in the dispensing chart. As Dr E acknowledged, he was aware that Ms A had quite specific views on what medications she did — or did not — want, and this could make it difficult for medical staff conducting her care.

231. I also consider that Dr E's charting of PRN zopiclone is not clear, and suggested that Ms A could be given up to three zopiclone tablets for sedation if required (although there is no evidence that this occurred). I agree with Dr Maplesden's mild criticism of this prescribing — both its lack of clarity and the fact that it was not best practice use of the drug, which is to prescribe as low a dose as possible for as short a period as possible.

232. Finally, I note that there was no response from Dr E's practice following the fax sent at 1.20pm on 23 Month7, which contained Ms A's vital signs and neurological observations, for some two hours, during which period RN D followed up the fax on two occasions with telephone calls. Whilst it is clear that Ms A was by this time acutely unwell, I am mildly critical of the time delay in responding to the fax and follow-up telephone calls.

Names have been removed (except Bupa Care Services NZ Limited and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

233. I recommend that Bupa:

a) Provide to HDC, within three months of the date of this report, an update on:

   i. the finalisation and implementation of the Pressure Injury Prevention and Management policy and education pack, and the Short Term Care Plans policy;

   ii. its implementation of the electronic medication management and electronic incident management systems;

   iii. its Clinical Manager Framework and Orientation Programme;

   iv. the position description: Clinical Manager; and

   v. the implementation of the proposed new role of roving Clinical Manager identified in Bupa's response dated 31 July 2015.

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

234. I recommend that RN C provide a written apology to Ms A's family for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

235. I recommend that RN D provide a written apology to Ms A's family for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

236. I recommend that RN B provide a written apology to Ms A's family for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

Follow-up actions

237. Bupa Care Services NZ Ltd, RN D, and RN B have been 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.

238. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Coroner.

239. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services NZ Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN C, RN D, and RN B.

Names have been removed (except Bupa Care Services NZ Limited and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

240. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services NZ Limited, will be sent to the DHB, the Health Quality and Safety Commission, and the Ministry of Health (HealthCERT). The District Health Board will be advised of the names of RN C, RN D, and RN B, and the name of the facility. The Ministry of Health (HealthCERT) will be advised of the name of the facility.

241. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services NZ Limited, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

242. The Director of Proceedings filed proceedings by consent against Bupa Care Services NZ Ltd ("Bupa") in the Human Rights Review Tribunal. The Tribunal issued a declaration that Bupa breached Right 4(1) of the Code by failing to provide services to Ms A with reasonable care and skill.

243. The Director did not take any proceedings against RN D or RN B.

Names have been removed (except Bupa Care Services NZ Limited and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Dawn Carey:

“1. Thank you for the request that I provide clinical advice in relation to the concerns from [the Coroner] about the care provided to [Ms A] by [the facility]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner’s Guidelines for Independent Advisors. My advice is limited to the nursing care provided to [Ms A] during [Month7] at [the facility].

2. I have reviewed the following documents on file: responses to the Coroner by the various providers involved in [Ms A’s] care including a report from Mr G on behalf of [the facility]; report for ACC [on behalf of the facility]; response to HDC from BUPA Care Services (BCS) including organisational policies, [Ms A’s] clinical file; [Hospital 1] clinical notes; [Hospital 2] clinical notes.

3. [Ms A] became a hospital level resident at [the facility] on 23 [Month1, following a period of hospitalisation for a relapse of her multiple sclerosis (MS), which was unresponsive to treatment. She was also a type 2 diabetic (on insulin), had a permanent cardiac pacemaker for complete heart block, syndrome of inappropriate anti-diuretic hormone (SIADH), and depression. As a result of the MS, [Ms A] was paraplegia, blind in her left eye and required a long term urinary catheter. She also experienced ophthalmic flare ups due to the MS. [Ms A] developed a sacral pressure injury in [Month7].

   On 23 [Month7], [Ms A] was transferred as an emergency to [Hospital 1]. Due to a presumed diagnosis of sepsis secondary to the sacral pressure injury, she was transferred to [Hospital 2] where she underwent surgical debridement. Post operatively she was managed in the intensive care unit where despite maximum inotropic support and ventilation, her condition became unsupportable. [Ms A] died at approximately 8.26 am on 24 [Month7].

4. A comprehensive response has been obtained from BCS on behalf of [the facility] and is on file. I note that the response details are consistent with the contemporaneous notes. For the purposes of brevity, I have not repeated the response details or the remedial actions borne out of the internal investigation in this advice. I note that the response acknowledges that had a medical review of [Ms A] been made earlier, a hospital admission may have been avoided.

5. I have been asked to review the nursing care provided to [Ms A] at [the facility] and to specifically respond to the following questions:
   - Was enough attention given to her dietary needs?
   - Was the Braden assessment an accurate reflection of her risk?
   - Should advice have been sought from a specialist wound care provider and when?
   - Was [Ms A’s] pain management appropriate?

- Should a medical review have been sought prior to 23 [Month7]?
- Were there any physical/clinical indications that should have alerted the nursing staff to [Ms A's] developing sepsis? Would they have been expected to observe for this?
- Any other comments

6. Review of clinical notes

   i. 2 [Month7]: Care giver progress notes (PN) entry reports [Ms A] as having ... *a pressure injury bruising on her bottom ... Have encouraged her to stay off bottom until mealtimes ... The RN assessment identified this as a grade 1 non-blanchable redness ... skin intact ... Short term care plan and wound management plan ... commenced. Accident/Incident form completed ... Wound noted to be 12cm length and 16 cm in width, not in pain ... She's aware of the need to be turned on her sides every 2 hourly* ... Night duty documentation reports [Ms A] being compliant with turns overnight.

   Comment: It was appropriate and expected that the care giver noted, documented and alerted the RN to the change in [Ms A's] skin integrity. The subsequent RN actions and documentation were also consistent with accepted standards and within an appropriate time frame.

   ii. 3 [Month7]: PN reports the Clinical Manager (CM) and duty RN discussing interventions to reduce further skin breakdown with [Ms A]. Due to previously experiencing associated discomfort, [Ms A] refused to have an air mattress on her bed. She agreed to being turned at two hourly intervals but only during the day time. Subsequent documentation reports [Ms A] being compliant with day time turns but complaining of left shoulder pain. This was alleviated with administration of 'as required' (PRN) oral tramadol. Night duty documentation reports [Ms A's] ... *complaint that everyone is blaming her for not turning ... She also requested to not disturb her when she was sleeping ...*

   iii. 4 [Month7]: [Ms A's] sacral dressing was renewed as it was no longer intact. Assessment notes ... *wound appears exactly same ... skin still intact* ... The wound evaluation (WE) chart reports the wound condition as remaining unchanged when next reviewed on 8 [Month7].

   iv. [Ms A's] risk assessments were updated on 7 [Month7]. Her Braden Scale score identified her potential risk of pressure injury as 14 (moderate risk). The completed mini nutritional assessment (MNA) form reports [Ms A] as malnourished.

   Comment: In my opinion the completed MNA is incorrect with unreliable scores inputted. This affects the validity of this assessment.

   There is also inconsistency when the MNA data is compared with the nutrition section of the completed Braden Scale. I note that both assessments are signed by the same RN.

v. 9 [Month7]: [Ms A] was reviewed by [Dr E] (GP). Nursing staff report his assessment as ... *pressure area is superficial and with good nursing care will heal fully without affecting full thickness. Meanwhile [Ms A] has accepted to have a pressure mattress on her bed* ... Afternoon documentation notes the air mattress being placed on [Ms A's] bed and handing over the task of redressing her sacral wound to the next shift. At 10pm care giver documentation notes ... *bottom very red, broken skin black spots on either side. RN notified.* WE documentation reports [Ms A's] dressing being done and that the RN considered the wound to be deteriorating. It appears that this dressing was completed by the night staff RN.

   Comment: It appears that [Ms A's] dressing was not renewed in a timely fashion. The care giver commentary would indicate wound deterioration having occurred after [Dr E's] review.

vi. On 10 [Month7], WE documentation reports a significant change, with the wound bed now including slough and necrotic areas. Wound care plan and intervention remained unchanged. Over the next week, WE documentation reports deterioration as a noted feature with the extension of the necrotic area. There is one reference to a hydrogel — Intrasite — being used but this use is not sustained despite increasing slough and necrotic areas. PN documentation by nursing staff includes ... *the pressure sore looks really bad* ...

   Comment: Slough and necrotic tissue is non-viable and its presence delays wound healing. Debridement is the process of removing such tissue and is an important part of wound bed preparation and management of infection. Intrasite gel is a topical desloughing and debriding hydrogel.

vii. On 16 [Month7], [Ms A's] multi disciplinary review (MDR) meeting was held. MDR documentation acknowledges the presence of her sacral pressure sore. The WE assessment for the previous day notes a deteriorated wound and the presence of odour and pain. PN update post MDR reports ... *during the night she likes not to be disturbed ... she is not [sic] fancy of air bed but just adjust the air and make her comfortable* ... Subsequent reportage includes [Ms A] complaining of discomfort and her mattress being found to be ... *not full of air. It was put down to 3* ...

   Comment: The pressure in [Ms A's] air mattress was determined by her weight. Reducing the pressure would impair the pressure relieving quality of the mattress.

viii. 17–19 [Month7]: PN entries report [Ms A] being withdrawn, eating less and refusing turns. Recorded blood sugar levels (BSL) are elevated from baseline trend. Due to increasing exudate volumes, the wound dressing product was changed.

ix. 20 [Month7]: Entries report [Ms A] declining cares ... *very low mood ... not talking much ... She is not drinking well. Her condition of health is deteriorating* ... Vital signs — blood pressure, temperature, pulse rate, oxygen saturations (SpO_2) — were checked. Excepting the SpO_2 reading

— 90% — the vital signs taken were within a similar range to those taken on 4 [Month7]. Respiration rate is not recorded. Night duty RN documentation describes [Ms A] as ... *too much deteriorated* ... but that as her care plan stipulated that she was not to be disturbed at night her vital signs were not checked. At 6am [Ms A] is reported as being *confused ... she seemed to be visually hallucinating ... and refusing to have her vital signs checked.*

x. 21–22 [Month7]: Documentation continues to report lack of responsiveness, with poor dietary intake and refusal of fluids. Elevated BSL recordings continue. WE assessment continues to report deterioration with the edges of the wound now being described as macerated.

xi. 23 [Month7]: [Ms A] is non responsive and ... *she is also not reacting to the pain stimuli* ... CM advised the duty RN to contact the GP and complete vital sign observations. At 1.10pm and 2.45pm recorded vital signs indicate [Ms A] is comatose, pyrexial, bradycardic, hypotensive and tachypnoeic with SpO_2 93%. A fax was sent at 1.20pm to the GP practice requesting a house call. The fax included [Ms A's] vital signs — pulse 49, BP80/50, respiration 48 (rapid, effortless), temperature 38.7°C, BSL 19.4mmol/L (before insulin), SpO_2 94%. At 3.15pm, the GP surgery contacted [the facility] and advised that [Ms A] should be sent to hospital. This was done via [the ambulance service].

7. Further comments

i. A pressure ulcer is an injury to the skin as a result of constant pressure due to impaired mobility. The pressure results in reduced blood flow; eventually causing cell death, skin breakdown, and the development of an open wound. Within the literature it is identified that a pressure injury can occur in an immobile person in a short period of just two hours.

ii. In general, wounds are covered so that the protective qualities of the skin and the optimal environment for healing — clean, moist, warm wound bed — can be maintained. Every time a dressing is removed from an open wound, the temperature of the wound bed drops. This drop causes the healing processes to pause until the wound bed returns to body temperature. Timely dressing renewal is necessary to prevent a prolonged loss of wound bed temperature and the wound bed from drying out due to exposure. The submitted organisational Wound Management Policy acknowledges the risks associated with prolonged dressing processes.

8. Clinical advice

i. Was enough attention given to her dietary needs?

In my opinion, more should have been done to ensure that [Ms A] was consuming an adequate amount of protein once she had developed a pressure injury. I am also critical that a nutritional assessment could identify a resident as 'malnourished' with no interventions to manage this identified risk eventuating. Whilst I acknowledge that I consider the completed assessment to have errors, I am critical that staff would

repeatedly record poor dietary intake from 10 [Month7] but without appropriate actions being implemented.

ii. Was the Braden assessment an accurate reflection of her risk?

Yes. The Braden Scale is a valid and reliable risk assessment that scores a person's risk of pressure injury formation. Its utility is solely focussed on risk calculation with the expectation that the clinical user links the risk assessment findings to suitable preventative measures. [Ms A] had some of the risk factors for pressure injury formation and the moderate risk assessment score reflects this. Usual interventions associated with a moderate Braden Scale score would include regular turning, using pressure reducing aids such as a specialised mattress, optimising nutritional intake and managing the risk problems identified such as friction/shear forces.

iii. Should advice have been sought from a specialist wound care provider and when?

Yes. I am concerned that there was a lack of responsiveness to the changes being recorded by nursing staff. From 10 [Month7], wound deterioration was noted but without corresponding changes to the wound care plan and interventions. I am critical of this. I consider that specialist wound care advice should have been sought on 15 [Month7]. [Ms A] had her pressure injury for almost two weeks at this stage and it was deteriorating despite regular wound care.

iv. Was [Ms A's] pain management appropriate?

[Ms A] was prescribed PRN analgesia — paracetamol, ibuprofen and tramadol hydrochloride — to manage her pain experience. Medication administration records (MAR) show analgesia was administered in accordance with the prescription. The IOWA pain assessment chart was consistently used when [Ms A] complained of pain and to evaluate the effectiveness of administered analgesia.

I consider that [Ms A's] pain management was appropriate and consistent with accepted standards.

v. Should a medical review have been sought prior to 23 [Month7]?

Yes. I consider that a GP review should have been sought on 18 [Month7] due to [Ms A] being a diabetic immobile resident who had a deteriorating sacral pressure injury and who was now withdrawn, upset and with a poor dietary intake.

vi. Were there any physical/clinical indications that should have alerted the nursing staff to [Ms A's] developing sepsis? Would they have been expected to observe for this?

Multi centre international research studies have resulted in the adoption of agreed definitions for SIRS, sepsis, severe sepsis and septic shock. Sepsis is generally recognised by abnormal vital signs and unwellness. While

there was a lack of comprehensive assessment of [Ms A's] vital signs prior to 1pm on 23 [Month7], nursing staff were noting signs that were concerning them — hallucinations and confusion; looking very unwell; cold and pale limbs with capillary refill of 6 seconds. These signs are indicative of sepsis, which may not have been recognised by [the facility] nursing staff. As a nursing peer I would expect all nurses to be aware that all wounds have the potential to become infected. [Ms A] had a sacral pressure injury which was at high risk of becoming infected because of its location. I would also expect all nurses to be aware that wound infections can become systemic and that some patient cohorts such as insulin dependent diabetics are more vulnerable to this than others. I consider that regardless of whether the [facility] nursing staff had uptodate knowledge of sepsis, they were aware that [Ms A's] condition was deteriorating. The only appropriate action following this realisation would be to seek medical input and to do so promptly. In my opinion, observing for changes in a resident's condition and acting on them in accordance with their scope of practice are expected and necessary actions of a RN/EN.

vii. Any other comments

a. [Ms A] had an existing grade 1 pressure injury on her sacrum when her Braden score was updated. The presence of existing skin damage does not influence the Braden Score but it should cue the RN to re-evaluate interventions focussed on managing the resident's risk. In my opinion this was not adequately done in this case.

b. As an insulin dependent diabetic, [Ms A] had a predisposition for impaired wound healing. There are also attributed behaviours — refusal to be turned/repositioned overnight, refusal to have dressings reapplied promptly — that would negatively impact on the healing of a sacral pressure injury and increase the likelihood of further deterioration. While I appreciate the need to work in partnership with health consumers and respect their preferences, I hold the opinion that a discussion concerning the consequences of not being repositioned would need to be discussed and explained to [Ms A] when her sacral pressure injury was noted to deteriorate. In my opinion, such information was necessary for [Ms A] to make an informed decision about her care interventions. I consider that this would be a very valid part of the discussion following her MDR — 16 [Month7] — and am critical that it was not so.

c. [Ms A] was prescribed zopiclone both as a regular and PRN medication. Under regular packaged medications — zopiclone 7.5mg tablet. Take one tablet at night. The pre-printed times on the medication chart indicates that administration should occur at 9pm. Under PRN medication dated 1 [Month5] — zopiclone 1–2 nocte prn for insomnia. Based on the MDR checklist [Ms A's] medication chart was reviewed by the GP on 11 [Month7]. The submitted MAR show regular incidences of [Ms A] being administered PRN zopiclone 7.5mg between 2am and 6.30am, with administration mainly occurring after 4am. On 21 [Month7], zopiclone 7.5mg was

administered at 2pm. Corresponding PN documentation report continuing day time sleepiness affecting care provision and nutritional intake.

I am concerned that nursing staff would regularly administer zopiclone to [Ms A] during ante meridiem (AM) hours and disagree with such administration practice. I do not understand the clinical rationale behind the decision to administer zopiclone to [Ms A] at 2pm on 21 [Month7].

9. Conclusions

Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements, and are supported by appropriate standards. Following a review of the [facility's] notes, I am of the opinion that the care provided to [Ms A] departed from accepted standards in relation to wound assessment and management. I am also of the opinion that [the facility] nursing staff should have initiated communication with [Ms A's] GP prior to 23 [Month7]. Overall, I consider that there was a lack of appropriate assessment, critical thinking and action in response to [Ms A's] deteriorating condition and consider that the provided nursing care significantly departed from accepted standards in relation to Principle 4. I also have reservations about the medication administration practices of [Ms A's] zopiclone medication."

The following further expert advice was obtained from RN Dawn Carey:

"Thank you for the request that I provide further clinical advice in relation to the complaint from [the Coroner] about the care provided to [Ms A] by [the facility]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. This advice is limited to the nursing care provided to [Ms A] and should be read in conjunction with previous advice dated 23 June 2015.

I have reviewed the following additional information: [DHB] letter dated 25 July 2015; response from [RN C] dated 27 July 2015; Ministry of Health letter dated 30 July 2015; responses from BUPA Care Services (BCS) including further response dated 31 July 2015 containing staff statements, policies and guidelines, care home manager (CHM) job description, clinical manager (CM) job description, orientation records, RN job description, statement from RN H dated 27 July 2015, statement from RN J dated 4 August 2015; statement from [RN D] dated 20 August 2015; further response from BCS dated 6 October 2015; communications from [Ms A's] family members; clinical advice dated 23 June 2015.

In addition to the advice that I have previously provided, I have been asked to review the additional information received and to comment specifically on the following:

Clinical Manager [RN C's] induction

[RN C] reports commencing employment at [the facility] on 28 [Month5] and that her orientation consisted of two weeks working at another BCS facility plus a few days at [the facility] working with the unit coordinator/acting CM. She reports that her ... *orientation didn't cover all aspects of the job that I was required to do ....* Approximately two weeks after she commenced employment a new CHM was appointed to [the facility]. [RN C] reports expressing concern that with the new CHM taking leave during [Month7], she would be on her own so soon after starting and feeling that these concerns were brushed aside; ... *I was told I could call if there were problems ...*

The CM Orientation Record Book (ORB) reports that the BCS orientation/induction period is three months in length. It covers generic plus role specific aspects and records signoff by both the employee being orientated and orientator. The ORB refers to a 'follow up' meeting occurring halfway through the orientation period. The paperwork that accompanies this meeting requires the employee being orientated to identify issues they would like more information about plus detailing what they are unsure of.

A statement from the CM — [RN H] — who orientated [RN C] at another BCS facility, reports that [RN C] accompanied her on her rounds each morning and followed her normal daily routine as a CM. [RN H] reports orientating [RN C] to processes including management of facility manager reports and incident forms, staff handover meetings, multi-disciplinary review (MDR) meetings and attended at least one. These aspects are signed by both [RN H] and [RN C] in the submitted ORB. [RN H] also reports that there were occasions when [RN C] forgot to bring her ORB which meant that all the items that were covered were not signed off ... *I recall that some time later once [RN C] had returned to [the facility], her orientation book was couriered to me so that I was able to sign off some of the outstanding items. As there were some areas that I could not remember discussing, I was not able to sign off everything ...*

The response from BCS reports that on 18 [Month6], [RN C] commenced responsibility as CM at [the facility] with [RN H] available as an off site CM 'buddy' resource. From 18 [Month6]–11 [Month7], it is reported that [RN C] worked under the guidance of a BCS relief manager who then handed over the role to the new CHM. While BCS acknowledges that [RN C's] orientation was fragmented due to relieving managers and the appointment of a new CHM ... *this was compounded by [RN C] being unwell and on sick leave for 25% of her time with us ... [RN C's] 3 month appraisal should have taken place around end of Month8 ; however this was delayed until 10 Month10 due to her sick leave and meetings being frequently re-scheduled ....*

In my opinion, it is not uncommon for senior clinical management roles to include orientation in another facility. I also consider it reasonable that [RN C's] orientation focussed on organisational processes with attention being given on where resources such as policies are stored and who to access for advice. I note that the ORB required and specified organisational policies to be read and signed when completed by the orientee. In my experience, self-directed learning is common in clinical orientation programmes. I consider the submitted ORB to be

typical of such records. I note that BCS have confirmed that [RN C] did not have the expected 'follow up' meeting during her orientation period. This meeting was due on 8 [Month7] approximately. In my opinion, a meeting during the orientation period to capture progress and concerns is essential and especially so for senior roles. BCS report that the meeting would have been facilitated by the CHM who at the time was new to the organisation and orientating himself. BCS are unsure as to the specific guidance that was provided to the new CHM concerning the need to arrange a 'follow up' meeting with [RN C].

While I consider [RN C's] overall induction to the CM role reasonable I am critical that the 'follow up' meeting was not offered to her.

BCS policies and procedures

I have reviewed policies and guidelines that were in place during [Month7] and pertain to nutrition, hydration, skin integrity, wound management, pain, medical assessment and care planning. I consider the reviewed BCS policies and guidelines to be clinically appropriate and of a high standard.

To avail of the learning in this case, I would recommend that timescales for evaluating progress towards healing is included in the wound management (WM) policy. Pan Pacific wound guidelines[1] report that with optimal care, improvement should be visible in two weeks for both partial and full thickness pressure injuries. In my opinion, the inclusion of a timescale would help guide nurses as to when to consider a referral for specialist input.

Changes made by BCS as a result of [Ms A's] death

In the response dated 18 May 2015, BCS detailed a number of practice changes and remedial actions that occurred following the internal investigation into [Ms A's] care at [the facility]. These consist of greater managerial oversight through daily and weekly meetings, including a review of residents with current wounds; nursing handover changes including a bedside/visual check of all residents assessed as unwell; education and coaching on wound care, effective clinical communication (ISBAR), roles and responsibilities, and the learnings from the internal investigation into [Ms A's] care.

BCS' additional response reports that further process changes have occurred since their initial response. This included a review of the senior clinical team and the determination that with only 32 residents at [the facility], there was a blurring of responsibilities between the Unit Coordinator (UC) role and the CM role. Following the current UC transferring to another BCS facility, the role was disestablished at [the facility] and coordination responsibility of the hospital unit devolved to the CM. Due to the CM — [RN C] — taking extended sick leave and then resigning, a CM at another BCS facility plus [the facility] CHM now provide the necessary levels of clinical support, oversight and leadership in accordance with the changes detailed in initial BCS response. It is reported that a permanent CM is being recruited for [the facility]. Also BCS are seeking to appoint a 'roving

[1] Australian Wound Management Association (AWMA). *Pan Pacific clinical practice guideline for the prevention and management of pressure injury.* (Cambridge Media Osborne Park, WA: AWMA, 2012).

CM' who would be utilised to assist in the orientation of new CMs to work alongside them in their facility.

In my opinion, the actions and process changes reported are appropriate. I do consider that [Ms A's] Multidisciplinary Review (MDR) on 16 [Month7] was a lost opportunity for the GP and nursing staff to review [Ms A's] use of PRN zopiclone. I would recommend that BCS consider including a process where a resident's usage of PRN medications is consistently and effectively communicated to the GP as part of a resident's MDR.

The overall management provided by [RN C]

[RN C] reports that *...during the month of [Month7], while the* [new CHM] *was away and so soon after starting my job, I was feeling extremely overwhelmed and not very well supported in my new role* ... She does not refer to accessing support from her off site CM 'buddy' or whether there were barriers that prevented this. Her response consistently reports ... *if I had been informed* ... he would have arranged for medical reviews, specialist input etc. She reports that as a result of this experience she will now ... *always ask questions, don't leave it to others to tell what I want to hear. Actively seek information from staff I am working with ...*

[RN C] reports that [Ms A's] MDR was led by RN B and that ... *it was stated [Ms A] had a small wound, but no concerns were discussed about it or any other cares* ... In my opinion, the presence of a sacral pressure injury in a diabetic, bed/wheelchair bound resident who has reluctantly accepted an air mattress and refuses to reposition overnight equates to a concerning combination. I consider that any experienced RN would share such concern. If that RN was in a managerial role I would expect them to question the reporting RN accordingly and/or review the wound care documentation. I note that [RN C] reports subsequently being informed that [Ms A] was not eating but not being aware that she also had a deteriorating pressure injury at this time. While I can appreciate that the nurses may not have consistently communicated concerns effectively to [RN C], I hold the opinion that as a CM, the responsibility lay with her to clarify and check. In my opinion, clinical oversight and leadership are integral parts of any clinical managerial role.

In relation to the zopiclone administration, [RN C] reports ... *I recall from nursing staff [Ms A] declined to take two sleeping tablets at the same time ... and wanted to have one for later in the night/early morning ... This I recall from staff was a long standing practice/request of [Ms A]* ... [Ms A] became a resident at [the facility] on 23 [Month1. The PRN prescription for zopiclone is dated 1 [Month5]. [RN C] commenced responsibility on 18 [Month6]. I do not view such a time line as 'long standing' but regardless I disagree that it was appropriate for nursing staff to consistently administer zopiclone between 2am and 6.30am. I am critical that [RN C] did not address this practice as soon as she became aware of it. If it were unregistered care givers participating in such poor medication practice, I would expect that their medication competence certification be revoked immediately.

The submitted clinical file has a retrospective entry by [RN C] dated 23 [Month7], *13.30 — RN on duty informed me re [Ms A's] condition @ 11.00 I spoke to [Ms A] although she didn't respond. Requested for RN to contact GP and obs to be*

done + neuro obs due to [Ms A's] unresponsiveness. [Ms A's] vital sign observations taken at 1.10pm and 2.45pm indicate coma and sepsis. At 1.20pm, RN D sent a fax to the medical centre ([the medical centre]) reporting these vital and neurological signs.

I have concerns that [RN C] would review [Ms A] at 11am and not realise that she was significantly unwell and in need of hospital level care. In my opinion, [RN C's] response to [Ms A's] unresponsive presentation was inadequate and inappropriate. I am critical that this response came from a RN and especially one in a clinical managerial position. In my opinion, [RN C] failed to appropriately assess, think or act in accordance with professional nursing and health standards[2].

The care provided by the following staff members, in particular in relation to the management of [Ms A's] wound and nutrition, the timeliness of follow up action taken (and with whom the responsibility for this follow up lay), and the administration of zopiclone:

[RN D] (UC)

I have reviewed [RN D's] statement. [RN D] reports working as the RN/UC at [the facility] for 3 years and that she is currently employed at another BCS facility. [RN D] reports ... *until 23rd [Month7] I did not see [Ms A] as being very unwell. I really apologise that I focused on the things that were happening around [Ms A] [...] and her mental well being, and focused less on the things that were affecting her physical well being...*

On 9 [Month7], [RN D] reports being present when [Ms A's] pressure injury was reviewed by [Dr E]. ... *I was on the opposite side so I did not view the wound ...* As the UC and RN coordinating the medical review of [Ms A] that day, [RN D] held the knowledge that [Ms A's] dressing had been removed and at what time this occurred. I note [Dr E's] medical consultation notes for this review was completed at 11.19am. I would expect [RN D] to communicate that [Ms A's] dressing needed to be renewed to the relevant RN and to do so promptly. The need for timely dressing renewals is endorsed by wound bed research[3]. In my opinion, [RN D] retained professional accountability for ensuring that [Ms A's] dressing was renewed in a clinically appropriate timescale[4]. I am mildly critical that [RN D] did not support [Ms A] to receive an appropriate level of wound care on 9 [Month7].

[RN D] reports ... *On 10th [Month7] I saw [Ms A's] pressure sore, which I recall was red. I do not remember seeing any black spots* ... This is contrary to [RN D's] contemporaneous WE documentation which reports the presence of slough and necrotic areas. I consider the contemporaneous wound evaluation to be a more reliable recall and remain critical that a RN would note deterioration in a wound bed and not instigate appropriate measures to manage this.

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[2] NCNZ, *Code of conduct for nurses* (Wellington, NCNZ, 2012) Standards New Zealand (NZS), *8134:2008 Health and disability services standards* (Wellington: NZS, 2008)

[3] William McGuiness, E Vella and D Harrison, "Influence of dressing changes on wound temperature", *Journal of Wound Care* 13, no. 9 (2004): 383.

[4] Nursing Council of New Zealand (NCNZ), *Guideline: Direction and delegation* (Wellington: NCNZ, 2008).

[RN D] reports [Ms A] requesting tramadol and zopiclone at 5.40am on 12 [Month7] ... *Even though I explained to [Ms A] that it was not the right time for her to take zopiclone as it was already morning, she insisted that she wanted it. I tried to further explain that the tramadol will help ease the pain without the need to take zopiclone but she said she wanted it. She rated the pain 4/6. So at 5.50am I gave her tramadol 100milligrams and zopiclone 7.5milligrams* ... As a RN I disagree with [RN D] administrating zopiclone to [Ms A] at 5.40am. I note the subsequent — day shift — PN entry reports ... *[Ms A] was too sleepy to eat her lunch ... After breakfast she just fell into sleep hence cares not maintained* ... [RN D] was a senior RN at [the facility] who regularly co-ordinated GP reviews and residents' MDRs. I am critical that [RN D] did not follow up on her experience on 12 [Month7] with appropriate action such as communication with the prescriber. In my opinion such follow up was necessary. I consider that [RN D] did not act in accordance with her professional responsibilities and am moderately critical of her medication administration practice and lack of management in this regard.

[RN D] reports next being involved in providing care to [Ms A] on Tuesday, 23 [Month7]; ... *we wanted to get [Ms A] up for a shower as she had gone days without one, as she refused showers when offered ... At around 0900hrs ... we got [Ms A] up on to the shower chair ... It was during the time we were attending to her hygiene cares that I observed [Ms A] was very unwell ... she just nodded or shook her head ... checked her observations and noted her temperature was high. Her BSL (19.1) remained high even after her morning dose of insulin BP. Her skin looked possibly jaundiced so I thought she had developed septicaemia.* At 1.20pm, [RN D] faxed the GP practice and requested a house call reporting vital signs that indicate significant unwellness. I am critical of the delay in taking [Ms A's] vital signs and recognising that she required comprehensive assessment. I consider that a comprehensive assessment of [Ms A] was more of a priority then showering her or renewing her sacral dressing. In my opinion, a fax to the GP was a completely inappropriate and inadequate response to the signs and symptoms that are recorded in the contemporaneous documentation and in [RN D's] statement. In my opinion, the care provided by [RN D] on 23 [Month7] was a significant departure from the accepted standards of nursing assessment and actions[5].

[RN J]

I have reviewed [RN J's] statement. [RN J] reports that she commenced employment at [the facility] in […]. She is currently employed at a different BCS facility. [RN J] reports being aware that while a RN could arrange for a wound specialist review ... *the practice had been that the Clinical Manager would make such referrals. However Registered Nurses would bring concerns about the condition of residents to the attention of the Clinical Nurse Manager. This would be done through a report in the Facility Manager's book (which I have not had access to in preparing this statement) ... The GP was in [the facility] twice a week and Registered Nurses could write in the GP's diary book if they wished a particular patient to be seen ... In hindsight, ... I also accept that I should have asked for a review by the GP for [Ms A's] deteriorating condition from 18 [Month7].*

[5] NCNZ, *Code of conduct for nurses* (Wellington, NCNZ, 2012) Standards New Zealand (NZS), *8134:2008 Health and disability services standards* (Wellington: NZS, 2008)

In my opinion, the care provided by [RN J] to [Ms A] 2–13 [Month7] inclusive was consistent with accepted standards of nursing care. I note that [RN J] was on afternoon duties on 17–19 [Month7] inclusive and involved in providing care to [Ms A]. I consider [RN J's] management of the noted wound deterioration — 17 [Month7] — to be remiss and agree that further communication and escalation of concerns should have occurred. I am unsure whether the [the facility] accepted practice at the time was followed and [Ms A's] wound deterioration noted in the Manager's book or not. My criticism of [RN J] would be mitigated if she made such a report.

I note that PN entries 17–19 [Month7], consistently report [Ms A's] poor nutritional intake. I am critical that [RN J] would note this in a resident with a deteriorating wound and not instigate clinical actions to increase the nutritional value or seek the input from the GP/Dietician. I consider that the care provided by [RN J] across these three days to be a mild–moderate departure from accepted standards of nursing care in relation to nutritional management. My criticism would be mitigated if [RN J] had communicated [Ms A's] wound deterioration in the Manager's book on 17 [Month7].

On 22 [Month7], [RN J] worked a night duty ... *At 01.10 hours ... still no answer or even non verbal gestures like nodding or shaking of her head ... Lower extremities and upper extremities are pale, capillary refill about 6 seconds ... Declined sips of water, not opening her mouth for mouthcare using swab ...* [RN J] checked [Ms A's] temperature which was unremarkable — 36.3°C. I am critical that a RN would note signs that are concerning and not complete a comprehensive assessment of all vital signs. I consider that medical advice should have been sought concerning [Ms A] and I am critical that it was not. In my opinion, the care provided by [RN J] on 22 [Month7] was a significant departure from the accepted standards[6].

[RN B] ([Ms A's] allocated nurse)

I have reviewed [RN B's] statement. [RN B] reports that she commenced employment at [the facility] in [Month4] and continues to be employed there. [RN B] reports [Ms A] as having a strong personality and that ... *nobody can convince her of anything ... during the night she wouldn't allow to be turned ... She was compos mentis ... made the care difficult* ... [RN B] reports that she handed over concerns such as [Ms A's] deteriorating wound and food intake to the UC and CM.

I note that [RN B] worked predominantly night duty shifts during [Month7] and regularly administered zopiclone to [Ms A] between the hours of 2am–6.30am. I note that following such administration times, [Ms A] was understandably sleepy during the day and that this affected her ability to eat adequately and receive an appropriate level of care such as the agreed two hourly turns. I consider such administration to be contrary to safe medication practices and am critical that this was consistent practice without thought of involving the prescriber.

[6] Ibid.

[RN B] completed [Ms A's] wound dressing on 9 [Month7]. While the care giver reports the presence of ... *black spots on either side* ... the WE completed by [RN B] is limited to granulating and epithelialising tissue with low levels of exudate. [RN B's] overall evaluation does report [Ms A's] wound as having deteriorated. On 11 [Month7], [RN B's] documentation at 6.30am reports *[Ms A] pressure sore dressing was exposed during the night. Tried to do the dressing but she refused and said she is sleepy* ... I note that this was following RN L administering zopiclone during the AM hours.

On 16 [Month7], [RN B] was present during [Ms A's] MDR and completed the review documentation. This reports [Ms A] ... *usually sleeps well during the night* and as having ... *a pressure area on her sacrum* ... I am critical of the lack of detail concerning [Ms A's] pressure injury especially as the WE documentation from the previous day identifies the wound bed as sloughy, necrotic, with a *foul odour* and moderate exudate. [Ms A] is also reported as experiencing pain from her wound, which was a new issue. The corresponding PN entry also details these wound assessment findings. I am moderately critical that a RN would be allocated to be a resident's nurse and be part of the MDR and not have reviewed the contemporaneous documentation. [RN B's] PN documentation reporting the MDR follows directly on from the previous RN reportage of significant changes and concerns. I am also concerned that [RN B] did not consider that [Ms A's] requests for PRN zopiclone should be addressed as part of her MDR.

On 21 [Month7], [RN B] completed [Ms A's] wound dressing noting an increase in necrotic tissue, odour, pain and macerated wound margins. [RN B's] overall evaluation was *deteriorated.* The wound care provided by [RN L] did not address the presence of non viable tissue. The presence of non viable tissue delays and impairs wound healing. At 2pm that day, [RN B] administered zopiclone to [Ms A]. This was following overnight reports of her having visual hallucinations and ... *appeared to be overdosed* ... plus day shift care giver reporting poor nutritional intake, poor urinary output and ... *confused a bit after morning tea* ... I am strongly critical of [RN B's] administration of zopiclone at 2pm and consider it to be a significant departure from nursing and medication standards. In my opinion, [RN B] should have sought medical advice concerning [Ms A] on 21 [Month7], and I am critical that she did not. I note that [the medical centre] […] has an after hours telephone triage service.

There is no RN documentation for morning shift on 22 [Month7]. Care giver (CG) entry reports [Ms A] as not eating breakfast, managing some ice cream at lunch time and declining turns. Based on CG reportage and the blood glucose level (BGL) monitoring chart, [RN B] was the duty RN. In my opinion, the CG reportage and [Ms A's] elevated BGL should have resulted in a comprehensive nursing assessment by [RN B].

I am very critical of the standard of nursing care [RN B] provided to [Ms A]. I consider that there are multiple moderate–significant departures from accepted standards of nursing[7].

[7] Ibid.

[RN L]

BCS response reports that [RN L] commenced employment at [the facility] in [Month3. I have reviewed [RN L's] statement. [RN L] reports working eight shifts in the hospital side of [the facility] in [Month7]. She reports that *I did not disturb [Ms A] by turning as per her request and as per her care plan. If [Ms A] rang the bell at night I turned her position ... she requested zopiclone when she wake up and told the GP has charted zopiclone as PRN so she can have it when she needed. Finally due to her pressure I gave her zopiclone ... I mentioned what happened on my shift in the next handover and recorded it in her progress notes ...*

In my opinion, the care provided by [RN L] to [Ms A] on 8 [Month7] was consistent with accepted standards of nursing care. I am critical of [RN L's] administration of zopiclone to [Ms A] at 6am on 15 [Month7] and consider it to be a moderate departure from safe medication practice. I note that following this [Ms A's] day time nutritional intake was poor ... *dozing most of the day, usual breakfast given but not eaten — didn't eat her lunch, baked beans requested but not taken, turns met, very sleepy today.*

[RN I]

I have reviewed [RN I's] statement. [RN I] reports that she commenced employment at [the facility] in [Month3] and that this was her first role as a RN in New Zealand. She continues to be employed at [the facility]. [RN I] reports [Ms A] appeared depressed […]. She reports [Ms A] as *...compos mentis as well as aware of her health status ...* [RN I] reports handing over everything which involves [Ms A's] wound condition and food intake level to the next duty RN so that the Clinical Manager/Unit Coordinator could be informed.

In my opinion, the care provided by [RN I] to [Ms A] 7–16 [Month7] inclusive was consistent with accepted standards of nursing care. I am critical that on 20 [Month7], [RN I] considered [Ms A] to be ... *not drinking well. Her condition of health is deteriorating ...* but did not instigate actions to manage these observations. I am also critical that the vital signs taken did not include [Ms A's] respiratory rate. I note that [Ms A's] oxygen saturation — 90% — reading was 5% less than on 4 [Month7]. I consider this to be a significant decrease. In my opinion, [RN I] should have sought medical advice concerning [Ms A] and I am critical that she did not. I acknowledge that there is no RN documentation for the morning shift on this day.

[RN I] also worked afternoon shifts on 21 and 22 [Month7]. Her documentation continues to report [Ms A's] lack of responsiveness and lack of dietary intake. She has recorded elevated BGLs with readings above 16mmols/L. PN entry on 22 [Month7] reports the presence of redness on the left side of [Ms A's] neck ... *it was around 5cm width and 6 cm long ... Her body temperature was 36.5°C ... Handed over to staff to monitor.* I remain critical of incomplete assessment of [Ms A] and lack of appropriate action in response to concerning signs and symptoms.

In my opinion, the nursing care provided by [RN I] on 20–22 [Month7] significantly departed from accepted standards of nursing care[8].

[RN K]

[RN K] has not supplied a statement. In my opinion, the nursing care provided by [RN K] on 3, 10, 13, 14, 18 and 19 [Month7] was consistent with accepted standards. I am moderately critical that [RN K] administered zopiclone between 4–5am on 8 and 20 [Month7] and consider it contrary to safe medication practice. I note that on 12 [Month7], [RN K] reported being unable to maintain the necessary level of care to [Ms A] due to zopiclone being administered at 5.50am. I would have expected such an experience to have resulted in [RN K] re-evaluating the appropriateness of administering zopiclone to [Ms A] during early morning hours and to have raised this with the prescriber. In my opinion, such follow up action is expected of a RN.

I am mildly critical that [RN K] did not prioritise [Ms A's] dressing on 9 [Month7]. At the time she handed this over, [Ms A's] wound was exposed for at least 4 hours.

[RN K] worked the night duty shift on 20 [Month7]. Her contemporaneous documentation describes [Ms A] as *... too much deteriorated ... She is just accepting all the things now at this stage ...* At 6.40am [RN K] describes [Ms A] as visually hallucinating and *... appeared to be low and overdosed. Refused to take observations at that time, saying that she is sleepy ...* In my opinion, after hours medical advice should have been sought by [RN K] and I am moderately critical that it was not.

On 23 [Month7] [RN K] was on a morning shift and checked [Ms A's] vital signs including neurological at 1.10pm and 2.15pm. At 1.10pm the recordings indicate [Ms A] as being comatose — GCS 6 consisting E4, V1, M1 — pyrexial, bradycardic, hypotensive and tachypnoeic. In my opinion, such findings indicate significant unwellness and the need for prompt hospital level input. In the context of a […] year old resident with an active resuscitation order, I consider that the only appropriate response would have been calling 111 and requesting an emergency transfer to hospital. In my opinion this should have been done immediately following the observations at 1.10pm. I am aware that [RN K] was delegated the task of taking [Ms A's] vital signs and that the UC and CM were involved in determining appropriate management. I note that the contemporaneous documentation by the UC refers to being aware of [Ms A's] comatose state. This somewhat mitigates my criticism of [RN K's] failure to respond. Had the UC not been aware I would consider [RN K's] failure to act on her assessment findings to be a significant departure from accepted nursing standards.

The following further expert advice was obtained from RN Dawn Carey:

"1. Thank you for the request that I provide further clinical advice on this case. In preparing the advice on this case to the best of my knowledge I have no

[8] Ibid.

personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documents: response from [RN C] dated 11 November 2015; response from [RN D] dated 12 November 2015; response from Bupa Care Services dated 23 November 2015; response from [RN B] dated 3 December 2015; response from [RN K] dated 23 February 2016; my previous clinical advice reports of 23 June 2015 and 8 October 2015.

3. Review of further information

a. [RN C] — Clinical Manager

I have determined no cause to amend my criticism of the level of oversight and management provided by [RN C] to the staff caring for [Ms A]. In my opinion [RN C] failed to provide the expected level of clinical leadership during [Ms A's] multidisciplinary review on 16 [Month7]. In addition, I continue to view [RN C's] response to [Ms A's] unresponsive presentation on 23 [Month7], as inadequate and inappropriate and consider her response to be a significant departure from accepted nursing and health standards.

b. [RN D] — RN and Unit Co-ordinator

I have determined no cause to amend my criticism or the level of departure concerning the nursing care provided by [RN D] to [Ms A].

c. Bupa Care Services (BCS)

The further response from BCS points out that [RN C] also had a responsibility to drive the meeting that should have occurred half way through her orientation programme. While I do not disagree with this stance, I consider that ensuring that an orientation programme is completed as per the employer's expectations is fundamentally the responsibility of the employer.

I note the remedial steps BCS have undertaken to improve their wound management policy, the multidisciplinary review process, clinical manager orientation and annual education programme. I also note that the introduction of an electronic medication management system will ensure that it will be easier to track a resident's use of PRN medications and to forward this information to the prescriber. In my opinion the changes that BCS have undertaken are appropriate and I have no further recommendations to add.

d. [RN B] — RN and [Ms A's] allocated nurse

I note that [RN L] advises that her documentation — 11 [Month7], 6am — that referred to [Ms A] refusing to have her dressing renewed as she was sleepy should have been dated 10 [Month7]. My previous advice commented that this was following administration of zopiclone during AM hours, this comment is still valid as [RN L] administered zopiclone to [Ms A] at 3am 10 [Month7].

Following a review of [RN L's] further response, I have determined no cause to amend my criticism or the level of departures identified. In my opinion, I consider the further education sessions that [RN L] has undertaken to be appropriate.

e. [RN K] — RN

Following a review of [RN K's] response, I have determined no cause to amend my criticism or the level of departures identified. I note that [RN K] is no longer employed at a Bupa facility.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the enquiry from [the Coroner] regarding the standard of care provided to [Ms A] (dec) prior to her death in [Hospital 2] on 24 [Month7]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. My advice is limited to the care provided to [Ms A] by her GP [Dr E]. I have reviewed the information on file: responses to the Coroner by various providers involved in [Ms A's] care including a response from [Dr E]; GP notes; response to HDC from BUPA Care Services, owners of [the facility]; [facility] care notes; [Hospital 1] and [Hospital 2] clinical notes.

2. [Ms A] suffered from multiple sclerosis (MS), diabetes requiring insulin, complete heart block with indwelling pacemaker, syndrome of inappropriate anti-diuretic hormone secretion (SIADH) and depression. As a consequence of her MS she was bedbound with paraplegia and requiring an indwelling urinary catheter. She also had ophthalmic symptoms and other neurological symptoms (including flares of symptoms) secondary to MS. [Ms A] had transferred to [the facility] from another long-term care facility in [Month1 and came under [Dr E's] care at that point. She required hospital level care and assistance with most daily living activities. [Dr E] visited [Ms A] regularly, on average about twice a month (BUPA response).

3. [Facility] care notes indicate [Ms A] was first observed to have a sacral pressure area on 2 [Month7] described as *pressure injury bruising on her bottom.* She was reviewed by a RN who noted *Grade 1 pressure sore, non blanchable redness.* The area was dressed and a more intensive turning regime adopted (see BUPA response for details). On 3 [Month7] [Ms A] complained to her carers of right eye symptoms ('rolling' eye and hallucinations) and [Dr E] was asked to review her. He did so at 1700hrs that day noting a rotatory nystagmus which he felt might be due to an MS exacerbation. [Dr E] discussed management with [Ms A's] neurologist who felt that, in view of lack of response of previous MS exacerbations to oral steroids, a 'watch and wait' was appropriate. It appears [Ms A's] pressure area was not discussed with [Dr E] on 3 [Month7].

4. [Dr E] reviewed [Ms A's] eye symptoms on 9 [Month7] and felt they were improving. He was asked to review the pressure area and noted *pressure sore on bottom, plan for air mattress, for 2hrly turns.* Caregiver notes provide more detail: [[Dr E]] *also checked the bottom→ pressure area is superficial and with good nursing care it will heal without affecting full thickness* …. In his response, [Dr E] states: *a pressure area was noted on the sacrum with redness and a dusky blue appearance to the skin.* He noted a wound care plan had been initiated. On 16 [Month7] [Dr E] states he enquired after [Ms A's] wellbeing and no concerns were raised with him by nursing staff. There is no record in the [the facility] notes of this contact.

5. [Facility] notes suggest there was a gradual deterioration in both the appearance of [Ms A's] pressure area and in her general condition (appetite and responsiveness) leading up to 23 [Month7] but [Dr E] received no notification of

these changes. However, on 23 [Month7] at 1320hrs [facility] staff faxed his practice requesting a house call for [Ms A]. The fax included recordings: pulse 49, BP 80/50, RR 48, Temp 38.7, blood sugars 19.4 and oxygen saturation 94%. Narrative included *[Ms A's] condition has greatly deteriorated especially today, she is not conversing and she is not taking anything orally ... has got Grade 2 pressure area on the sacrum.* [Dr E] was unavailable and staff at his practice felt it most appropriate [Ms A] be immediately admitted to hospital for review. Transfer to [Hospital 1] was arranged and there [Ms A] received fluid resuscitation and IV antibiotics prior to transfer to [Hospital 2] for further management of her suspected septic shock. There she was felt to have septic shock secondary to necrotising fasciitis associated with her sacral pressure area. She underwent emergency debridement of the pressure area together with active treatment of her shock and sepsis but sadly succumbed to the effects of sepsis on the morning of 24 [Month7].

6. Comment: [Dr E's] contribution to [Ms A's] care was appropriate to the level of information he received regarding her condition from nursing staff at [the facility]. He was not asked to review the pressure area until a week after it was first noted and management advice appropriate for a grade 1 pressure area was provided by him. I think it was reasonable for [Dr E] to expect notification by nursing staff if there were any further concerns regarding the pressure area, noting his impression there was a structured wound management process in place and the pressure area was superficial and likely to respond to appropriate nursing care. It is unclear why nursing staff were reassuring of [Ms A's] condition on 16 [Month7] when [Dr E] enquired after her wellbeing as care notes suggest there was already some deterioration in her pressure area by that time. It is also unclear why [Dr E] was not notified by nursing staff of continued deterioration in [Ms A's] pressure area and general condition over the days prior to her death until the more acute and catastrophic deterioration on 23 [Month7]. I think it is appropriate that expert nursing advice is sought on this case."

The following further expert advice was obtained from Dr David Maplesden:

"1. Thank you for the request that I provide further clinical advice in relation to the care provided to the late [Ms A] by [Dr E] — my original advice having ben provided on 20 May 2015. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. [Ms A] was taking zopiclone 7.5mg nocte prior to her admission to [the facility] and this was continued following admission, initially at a regular dose of 7.5mg nocte (as charted by [Dr E] on 20 [Month3]).

Comment: It would be expected that a medication charted as 'nocte' be given in the evening rather than after midnight. While long-term use of hypnotics is not regarded as best practice, it is common practice[1] and assuming [Ms A] was not suffering any ill-effects from her regular dose of zopiclone 7.5mg, and that she felt she was gaining benefit from the medication, I think it was consistent with common practice that the medication was continued following admission to the rest home.

[1] BPAC. Overuse of benzodiazepines: still an issue? Best Practice Journal. 2015;Issue 66

3. On 1 [Month5] [Dr E] states he reviewed [Ms A] who was complaining of shoulder pain. She requested an increase in her zopiclone dose as the current dose was not proving effective for her insomnia. [Dr E] prescribed ibuprofen and physiotherapy for the shoulder issue. He prescribed zopiclone on the PRN drug chart as '1–2 tabs nocte prn for insomnia' and the regular dose was not altered. [Dr E] states it was his intention that [Ms A] use only one extra dose of zopiclone and only when absolutely necessary — usually if she had had no sleep by the early hours of the morning and certainly before 0300hrs.

Comment: The prescribing in this instance was not clear and suggested [Ms A] could have up to three zopiclone tablets if required for sedation (although medication administration charts do not indicate she ever received this dose). By prescribing the medication as nocte, again I would expect the medication to be administered before midnight but reasonably up to 0300hrs if verbal advice was provided by the GP in this regard, although this instruction should have been recorded on the prescribing sheet. However, the manufacturers of zopiclone recommend a maximum dose of 7.5mg daily[2] and best practice use of the drug is to prescribe as low a dose as possible for as short a period as possible[3]. I am therefore mildly critical of [Dr E's] prescribing in this instance — both the unclear instructions which could have led to [Ms A] receiving three zopiclone tablets daily and the decision to double the dose of zopiclone albeit with instructions to limit the use of the additional tablet as much as possible. There is some evidence in the clinical notes that [Ms A] would delay sleeping at night, and behavioural modification of her sleep patterns might have been a preferable option to increasing her dose of hypnotic in the first instance.

4. [Ms A] evidently developed a pattern of requesting, and being administered, her additional zopiclone after 0300hrs and sometimes well into the morning. [Dr E] became aware of this when he undertook a medication review in early [Month6] and states he advised against this practice, instead encouraging [Ms A] not to stay up late at night. The prescription remained with the 'nocte' administration instruction.

Comment: I think the advice [Dr E] states he gave at this point was appropriate. I would not expect a medication review to involve perusal of the drug administration charts provided nursing staff were available to discuss any trends in PRN medication use. If [Dr E] had specifically advised against [Ms A's] use of zopiclone after 0300hrs, and noting the prescription instruction remained as 'nocte', I would expect nursing staff to have heeded these instructions and for [Dr E] to reasonably assume the instructions were being followed. I would be at least mildly critical if [Dr E] sanctioned the use of zopiclone after 0300hrs as this was likely to exacerbate [Ms A's] irregular sleep pattern and promote daytime drowsiness. I note [Ms A] was not walking — falls secondary to daytime drowsiness being one of the major concerns regarding use of hypnotics.

5. I have no further comments or recommendations regarding the management of [Ms A's] insomnia by [Dr E]."

[2] http://www.medsafe.govt.nz/profs/datasheet/a/apozopiclonetab.pdf Accessed 18 July 2016

[3] BPAC. Managing insomnia. Best Practice Journal. 2008; Issue 14