Oceania Care Company Limited
Registered Nurse RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 16HDC01013)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Mrs B, aged 87 years at the time of events, was a resident of a rest home. It was identified that she had a very high risk of developing pressure injuries.

Wound care and pain relief

2. On 11 Month5,[1] Mrs B had a broken area of skin in her sacral region. The wound was noted to have healed by 25 Month5. On 29 Month5, Mrs B had a grade 2 pressure injury on her sacrum. It is unclear if or when the pressure injury resolved; however, updated assessments on 17 Month6 noted that there were "no wounds present".

3. On 19 Month6, a grade 2 sacral pressure injury was documented. The pressure area became progressively worse, and by 30 Month7 it had become a grade 4 pressure injury. A swab was taken and the matter was escalated to the GP, who prescribed morphine for use prior to debridement and dressing changes. The wound was reviewed by the Clinical Manager, Registered Nurse (RN) C, on 31 Month7, and a referral to a wound specialist was made. In total, the wound was dressed for 29 days up until 3 Month8. There was no assessment of the effectiveness of Mrs B's new pain regimen.

Bowel activity

4. There were no documented actions in response to Mrs B's lack of bowel activity from 3 Month6 to 15 Month6 (12 days).

Care leading up to hospital admission

5. Entries in Mrs B's progress notes on 1 and 2 Month8 refer to good intake, and, at other times, to poor eating and drinking. Mrs B's fluid output was not documented.

6. On 3 Month8, Mrs B's daughter raised concern that Mrs B was confused, and in the evening Mrs B vomited up most of her bedtime medications. At 1am on 4 Month8, a bureau nurse documented that Mrs B had vomited again, and continued to vomit when turned. It was also documented that her temperature was 35.2°C, and her abdomen was distended and rigid with some tenderness on palpation. At 5am, the bureau nurse recorded that Mrs B was complaining of lower abdominal pain, felt cold and clammy, and appeared slightly confused. The bureau nurse also documented that she had spoken to RN C about admission to hospital, but was told to monitor Mrs B until the morning and then to reassess her. RN C denied that the bureau nurse queried admission or mentioned Mrs B's vomiting episodes.

7. At 6.30am, Mrs B was noted to have cyanosed lips and fingernails and a weak pulse, and she was disorientated. She was transferred to the emergency department (ED) at the public hospital, where she was diagnosed with an ischaemic bowel. Sadly, Mrs B died on the morning of 5 Month8.

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

Findings

8. The Deputy Commissioner found that the wound care provided to Mrs B was not of an acceptable standard, and did not comply with Oceania's policy on wound management. The Deputy Commissioner also considered that there was a lack of compliance with Oceania's pain management policy, and poor documentation in respect of Mrs B's input and output.

9. Further, the Deputy Commissioner found it concerning that Mrs B's constipation was treated infrequently, and that medical attention was not sought when her condition deteriorated.

10. Overall, the Deputy Commissioner found that by failing to ensure that Mrs B received services with reasonable care and skill, Oceania Care Company Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Recommendations

11. In recognition of the sale of the rest home, the Deputy Commissioner recommended that Oceania Care Company Limited satisfy itself that the deficiencies in the care identified in this investigation are not of concern in other facilities operated by the company. The Deputy Commissioner also recommended that Oceania Care Company Limited provide a written apology to Mrs B's family.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Oceania Care Company Limited. The following issues were identified for investigation:

- *Whether Oceania Care Company Limited provided an appropriate standard of care to Mrs B in 2015–2016.*
- *Whether Clinical Manager and Registered Nurse RN C provided an appropriate standard of care to Mrs B in 2015–2016.*

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

14. The parties directly involved in the investigation were:

Ms A	Complainant/consumer's daughter
Oceania Care Company Limited	Provider
RN C	Clinical Manager at the rest home

15. Further information was received from:

District health board (DHB)	Provider
General Manager for Aged Care at Oceania	
RN D	Registered nurse
RN E	Business and Care Manager at the rest home

16. Also mentioned in this report:

RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse

17. Independent expert advice was obtained from a registered nurse, Jan Grant, and is included as Appendix A.

Information gathered during investigation

Introduction

18. Mrs B, aged 87 years at the time of events, had been a resident of the rest home (more details below) since 2011. Her medical history on admission included atrial fibrillation,[2] ischaemic heart disease,[3] and a right knee amputation. She was able to mobilise using a wheelchair but required assistance with transfers.

19. Other notable medical events include a spigelian hernia[4] repair in 2014 and the development of a pressure injury[5] on Mrs B's left heel in 2015.

20. Mrs B was initially assessed as requiring a rest-home level of care; however, on 27 Month6, she was reassessed as requiring hospital-level care.

21. This report focuses on the standard of care and nursing assessment provided to Mrs B from Month1, up to her hospitalisation on 4 Month8. During this period, Mrs B became increasingly frail, and had a non-healing sacral pressure injury and experienced increased pain. Mrs B's food and fluid intake decreased in Month8, and her family expressed concerns about the marked deterioration in her condition.

[2] Very rapid uncoordinated contractions of the chambers of the heart, resulting in a lack of synchronism between heartbeat and pulse beat.
[3] A group of clinical syndromes characterised by an imbalance between myocardial supply and demand.
[4] A type of hernia (protrusion of an organ or part through a wall of the cavity in which it is normally enclosed) that develops through the spigelian fascia (the muscle found in the abdominal wall).
[5] Also known as bedsores or pressure ulcers, pressure injuries usually develop over "bony" parts of the body as a result of sustained pressure, or pressure and friction.

The facility and staff

22. At the time of these events, the rest home was owned and operated by Oceania Care Company Limited (Oceania). It was contracted by the DHB to provide rest-home, hospital, and dementia-level care. Between Month5 and Month8, the total number of residents ranged from 43 to 47.

23. The hospital wing, where Mrs B resided, had a registered nurse rostered on duty 24 hours a day, over three shifts. The registered nurse's responsibilities in respect of residents included documenting and reporting any changes or significant observations, informing the Clinical Manager of any changes, and supervising and checking dressings and wound care. The registered nurses were assisted by three care staff on the morning shift, and two care staff on the afternoon shift.

Sacral pressure injury management

24. A registered nurse assessment identified that Mrs B had skin integrity issues. The assessment form included ticks next to the columns for dry skin, red areas, scars/cuts, and rashes. Mrs B's Person-Centred Care Plan noted that she had a Waterlow Score of 25[6] (ie, she had a very high risk of developing pressure injuries). One of the listed goals was to maintain good skin integrity and to remain free from pressure areas for six months. The care plan outlined that moisturiser was to be applied to the top of Mrs B's foot and her buttocks.

25. On 2 Month1, a healthcare assistant documented that Mrs B had a small tear on her sacral area, which was reported to the enrolled nurse and the registered nurse. The tear showed good signs of improvement over the next two weeks, and was noted to have resolved by 14 Month1.

26. A turn chart was implemented on 29 Month1. It stated that Mrs B was to be turned side-to-side two-hourly overnight to take pressure off her back and sacrum. On 6 Month3, a healthcare assistant informed the enrolled nurse that Mrs B had a small area of broken skin on her sacrum. Micreme (an anti-fungal and anti-inflammatory cream) was applied to the area.

27. On the morning of 11 Month5, Mrs B complained of pain in the sacral region. RN F recorded in the progress notes that there was a broken area of approximately 0.5cm on the sacral cleft, and a small hole filled with white scabs. RN F cleaned and dressed the wound. She also prepared a Wound Care Plan and Management sheet and a Wound Assessment and Monitoring form in relation to the sacral pressure wound. It is recorded on the Wound Care Plan and Management sheet that the wound healed on 25 Month5, but no entries were made in the Wound Assessment and Monitoring form over that period. An Incident Report was not completed as per the Wound Management Policy.

[6] A tool used to estimate the risk of a given patient developing a pressure injury. A total Waterlow Score of >10 indicates risk for a pressure area. A very high risk score exists at >20.

28. On 29 Month5, RN G noted that Mrs B had a grade 2 pressure injury[7] on her sacrum. It was estimated to be approximately 0.2cm x 1cm. RN G cleaned and then dressed the wound, and notified the family. In addition, RN G completed an Incident Report and a Wound Assessment and Monitoring form but did not initiate a Wound Care Plan and Management sheet. The only entry in the Wound Assessment and Monitoring form consisted of RN G's observations on 29 Month5. In the Incident Report, RN G recommended two-hourly turns, and this recommendation was signed by both RN C and RN E. It is unclear if or when the pressure injury resolved; however, when RN F updated Mrs B's nutrition and hydration assessment on 17 Month6, she noted that there were "no wounds present". RN F did not tick the box for ulcers in the "skin integrity" section of the registered nurse assessment, which was completed on the same date.

29. On 19 Month6, RN F used the Braden Scale to reassess Mrs B's risk of developing pressure injuries.[8] Mrs B had a score of 13, signifying a moderate risk of developing a pressure injury. It was noted in the evening that Mrs B had a stage 2 sacral pressure sore that was approximately 0.5cm x 0.5cm in size, with superficial depth. RN H commenced a Wound Care Plan and Management sheet and a Wound Assessment and Monitoring form, with the goal of achieving "intact and healed skin without signs of infection within 1–2 weeks". RN H documented that Mrs B had a pain score of 3–4 out of 10 on changing the dressing. The Wound Assessment and Monitoring form was updated on 22 and 29 Month6, but no changes were recorded on these dates. However, the Wound Care Plan and Management sheet details that the wound was cleaned and dressed on 25 Month6. On this date, the wound was open and oozing slightly, and measured 0.5 x 1cm.

30. Mrs B's Person Centred Care Plan was updated by RN F on 2 Month7. RN F recorded that a short-term care plan had been commenced for Mrs B's pressure injury. The plan repeated that Mrs B was to have moisturiser applied to the top of her foot and buttocks. It also referred to frequent dressing changes and repositioning and daily rest after lunch.

31. An entry in the Wound Assessment and Monitoring form on 6 Month7 indicated that the wound had increased to 4cm x 1.5cm, had slough,[9] and was necrotic.[10] On 7 Month7, the pressure injury was noted to be a stage 3 wound.[11] It was cleaned and dressed on 8 Month7. The registered nurse noted that it now measured 4cm x 2cm and had a necrotic part. From that date, nursing staff made daily entries in the Wound Assessment and Monitoring form.[12] Although the form has a prompt for what percentage of the wound bed is necrotic (black), sloughy (yellow), granulating[13] (red), epithelialising[14] (pink), and

[7] A partial-thickness loss of skin that presents clinically as an abrasion, blister, or shallow crater.
[8] Mrs B's risk of developing pressure injuries was previously assessed using the Waterlow scale.
[9] A glutinous yellow covering consisting of a mixture of fibrin, protein, serous exudate, leucocytes, and bacteria.
[10] Describes tissue that has died.
[11] A full thickness of skin is lost, exposing the subcutaneous tissues. The wound presents as a deep crater with or without undermining of adjacent tissue.
[12] With the exception of 10 and 11 Month7.
[13] Composed of capillary loops, collagen, proteins, and polysaccharides.
[14] Epithelial cells (surface skin cells) migrate across the wound bed to complete the repair process.

hypergranulating,[15] on most occasions the boxes were marked with a tick instead of a percentage number. Further, the prompt for a pain score on the form was not completed by any of the nurses throughout Month7, despite ticks indicating the increases in severity of the wound, and that Mrs B experienced pain on dressing changes.

32. On 9 Month7, RN F met with Mrs B and her daughter, Ms A, regarding the management of Mrs B's pressure injury.

33. An entry on 15 Month7 stated that the wound had increased to 5cm x 3cm x 2.5cm, and was 25% necrotic. The slough was debrided,[16] and the wound was packed. An air mattress was instituted on 17 Month7. On 18 Month7, Mrs B's Person Centred Care Plan was updated to include food and fluid monitoring, two-hourly turns,[17] and the fact that she had been provided with an air mattress.

34. By 22 Month7 the wound was 6cm x 3cm x 3.5cm and was 45% necrotic with high exudate.[18] On 30 Month7, a wound swab was taken and sent to the laboratory. At 4pm, Mrs B was seen by a general practitioner (GP). Mrs B's daughter was also present. The notes from this visit indicate a stage 4 pressure injury[19] that did not appear to be infected. The GP recommended debridement and dressing of the wound once daily and as required, with morphine suspension for the pain. On 31 Month7, RN C reviewed the wound and made a referral to the Wound Specialist Nurse at the public hospital. RN C noted in the referral that Mrs B had poor food and fluid intake, and that they had been using honey dressing for the wound but it had increased in size and was getting deeper. RN C also telephoned Mrs B's daughter to inform her of the referral. Mrs B's wound was debrided on 1 and 2 Month8, following the administration of morphine.

35. Oceania's "Wound Management" policy provides that:

- A short-term care plan is used for simple wounds such as skin tears.
- A wound assessment is undertaken for wounds requiring more extended wound management.
- The Wound Care Plan and Management sheet is used to guide wound management and to evaluate its effectiveness.
- An assessment of the wound should be documented on the Wound Assessment and Monitoring form at every dressing change, and should include size tracings or photographic observation. Any changes to the treatment plan should be documented on the Wound Care Plan and Management Sheet with a reason for the change of treatment. The dressing change should be documented in the clinical notes along with

[15] An excess of granulation tissue that fills the wound bed to a greater extent than what is required and goes beyond the height of the surface of the wound, resulting in a raised tissue mass.
[16] Removal of unhealthy tissue from a wound to promote healing.
[17] Turn charts indicate that this intervention was instigated on 29 Month1.
[18] Material composed of serum, fibrin, and white blood cells that escapes from blood vessels into a superficial lesion or area of inflammation.
[19] A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

any observations of improvement and any changes to the management plan that have been made.

- A dressing's effectiveness should be evaluated after one week unless there is an adverse reaction to the product.
- Any wound that shows no signs of improvement in a three-week period should be referred to a wound care specialist, or GP advice should be sought.
- Skin tears, pressure injuries, and bruises should be reported on an incident/accident form.

Pain management

36. A pain assessment dated 17 Month6 identified that Mrs B experienced throbbing pain in her buttocks when sitting for too long, and that the pain was alleviated with analgesia as required, and frequent changes in positioning. At a family meeting on 9 Month6, Ms A had raised the issue of her mother's reluctance to request pain relief, and had asked that staff offer it at every medication round or as required. Ms A told HDC that Mrs B had indicated to her that her pain was usually 7–9 out of 10.

37. In early Month7, in keeping with the state of her sacral pressure injury, Mrs B's pain increased, yet paracetamol and codeine (to be administered four times a day as required) were not given consistently. RN C told HDC that Mrs B was very reluctant to take pain relief.

38. As detailed in paragraph 31 above, nursing staff indicated on the wound assessment form that Mrs B experienced pain whenever she had her dressings changed, but there are no documented pain scores throughout Month7.

39. On 30 Month7, the GP reviewed Mrs B's grade 4 pressure injury and prescribed morphine for use prior to debridement and dressing changes. The medication chart shows that morphine was given twice on 1 Month8, twice on 2 Month8, and once on 3 Month8.

40. Oceania's "Pain Management" policy, issued in July 2012, states: "The effectiveness of the treatment is evaluated after each dosage or treatment is given. This is to be recorded in the resident's progress notes and the pain monitoring tool." Contrary to this policy, staff did not use a pain monitoring tool to assess Mrs B's new medication regimen, and there was no evaluation of her response to the morphine in the progress notes.

Bowel activity

41. Records of Mrs B's bowel activity indicate that it was not unusual for Mrs B to go three or four days without passing a bowel motion. Enemas were given on 30 Month6, 4 Month7, and 1 Month8 (after Mrs B's bowels had not opened for four or five days), but there were also other periods of similar duration where no interventions took place for Mrs B's lack of bowel activity. Most notably, there are no documented actions in response to her lack of bowel activity from 3 Month6 to 15 Month6.

Mrs B's condition from 1 Month8

42. Ms A told HDC that on 1 Month8 she asked RN D to review Mrs B, as she was very pale, clammy, in pain, and had blue lips. Ms A stated that RN D took Mrs B's temperature, told her that it was OK, and left the room. There is no record of Ms A's concerns in the progress notes or on the "communication with family" form, and RN D said that he has no recollection of his shift on that date.

43. According to the latest registered nurse assessment (17 Month6), Mrs B had no eating problems and would typically drink 6–7 cups of fluid per day. An entry at 2.50pm on 1 Month8 stated that Mrs B had "poor food and fluids". Evening progress notes refer to "good food and fluid intake, no concerns"; however, no fluid intake was recorded on the fluid balance chart after 2pm. The nurse in the evening documented that Mrs B had "no complaint of pain".

44. The progress notes on 2 Month8 state that Mrs B had been "eating and drinking poorly". A later entry stated that Mrs B ate only a banana for dinner, but then had a cup of tea and some sandwiches for supper. On the food monitoring chart, it is recorded that Mrs B consumed all of her breakfast and morning tea, but did not have any of her lunch or afternoon tea. There are no entries under dinner or supper. The fluid balance chart records 150ml of tea as the only fluid intake on that date. The food monitoring chart for 3 Month8 shows that Mrs B had a half portion of breakfast, and had only tea for the rest of the day. The fluid balance chart states that Mrs B had 300ml of fluid in the morning, but there are no other entries after 10am. There is no record of fluid output on any of the charts provided to HDC.

45. Ms A told HDC that she visited her mother at 10.15am on 3 Month8. At 10.15pm, RN G documented that Ms A had expressed concern that Mrs B appeared confused. RN G wrote that she informed Ms A that staff would arrange for a urine dipstick,[20] but that Mrs B did not pass urine when she tried to obtain a specimen. RN G further recorded that Mrs B vomited up her bedtime medications except for the zopiclone. RN G took Mrs B's observations, all of which were within the normal range except her temperature of 35.4°C. RN G did not document the time at which the vomiting episode occurred, or when the observations were taken, but wrote that Mrs B was given Panadol once settled, and that her temperature was 35°C at 9pm.

46. A bureau nurse[21] on the night shift wrote at 1am on 4 Month8 that Mrs B had vomited again, and that she continued to vomit small amounts when turned. The bureau nurse further documented that Mrs B's abdomen was "quite distended and rigid" with some tenderness on palpation. Mrs B was noted to be coherent and orientated, though "a little vacant". Mrs B's temperature, at 35.2°C, remained abnormally low, but her other vital signs were normal.

[20] A chemically sensitive strip of paper used to identify one or more constituents (such as glucose or protein) of urine by immersion. The test can be used to check for a possible urinary tract infection.
[21] Casual nursing staff supplied by an agency.

47. At 5am, the bureau nurse recorded that Mrs B was complaining of lower abdominal pain, and felt "cold and clammy". The bureau nurse also noted that Mrs B appeared slightly confused. The nurse wrote:

> "Contacted [RN C] regarding possible admission. Decision made to monitor until morning then reassess. Bowels last opened 1 [Month8] — normal for [Mrs B] to have [bowels open] every 2/3 days."

48. RN C stated:

> "[A]t no time during that conversation did [the bureau nurse] express serious concerns about [Mrs B's] current health. My recollection is that the RN said that [Mrs B] had vomited once when turned but nothing since. There was no reference to vomiting or pain experienced the day before. I do remember asking about bowel motions, urinary symptoms and her current observation and was reassured that they were all within the normal range. Given the information provided I asked the RN to monitor her closely and call me back if she had any further concerns. I never heard from her again. I would not have said monitor until morning given it already was [5am]."

49. The General Manager for Aged Care at Oceania told HDC:

> "It is my understanding that out of normal business hours, the Registered Nurses were asked to ring the Clinical Manager, [RN C] to seek agreement to transfer a resident to [the public hospital]. This is not a national process used at other Oceania Healthcare facilities … the Registered Nurse on duty [on] 4 [Month8] documented the resident's symptoms in the progress notes. If these had been conveyed to [RN C], then the decision should have been made to transfer the resident. The Registered Nurse should have had the mandate to transfer the resident to [hospital] at her own discretion."

50. RN C denied that the bureau nurse had contacted her in relation to possible admission. RN C said that had the bureau nurse mentioned admission, she would have questioned her further as to why she felt this to be necessary, and would have gone down to the facility herself to confirm the bureau nurse's reasons and to support her in the admissions process.

51. By 6.30am, Mrs B's condition had deteriorated. Mrs B was noted to have cyanosed[22] lips and fingernails and a weak pulse, and was disorientated. The bureau nurse wrote that Mrs B was to be transferred to the ED at the public hospital for further assessment.

52. An entry by RN H at 8.30am stated that there was a faecal smell from Mrs B's mouth and a smudge of brown dry discharge from her oral cavity. RN C was updated, and Mrs B's morning medications were withheld on her advice.

[22] Affected by a bluish or purplish discoloration owing to deficient oxygenation of the blood.

53. Mrs B arrived at the public hospital at 8.45am.

Subsequent events

54. On presentation to the ED, Mrs B was noted to be alert but confused. She was clinically dehydrated, had cloudy purulent urine[23] from an indwelling catheter,[24] and a soft distended abdomen with pain on percussion, and rebound tenderness[25] in the lower left quadrant of her abdomen. Following an X-ray and CT[26] scan of the abdomen, Mrs B was diagnosed with an ischaemic bowel.[27] Surgical staff, Mrs B, and Mrs B's family agreed that surgery would not be in her best interests, and palliative care was commenced.

55. Sadly, Mrs B died on the morning of 5 Month8. The cause of death was noted as multi-organ failure owing to bowel necrosis/ischaemia.

Senior nursing staff availability and oversight

56. RN C was the Clinical Manager at the facility. Her role was to provide clinical leadership to clinical (nursing) and care staff, and to ensure compliance with Oceania policies, procedures, and contractual and audit requirements. RN C's normal working hours were 8am–4.30pm, Monday to Friday. She reported to the Business and Care Manager, RN E, whose normal hours were 8am–4.30pm, Monday to Friday. RN C and RN E alternated being on call after hours on a weekly basis.

57. RN C was on sick leave from 9 Month6 until 7 Month7, during which time RN E covered the Clinical Manager role. RN C stated that the deterioration in Mrs B's wound occurred when she (RN C) was on sick leave, and that the change in Mrs B's wound status was not handed over to her on her return. RN C also said that RN E continued to have control over key clinical responsibilities, such as wound care, weight control, and file audit.

58. In contrast, RN E told HDC that RN C resumed normal duties and responsibilities when she came back to work. RN E stated that there is no documented record of a handover, as generally handovers are verbal by nature. An Incident Report for a stage 1 pressure area[28] on Mrs B's foot on 16 Month7 identified that RN C was responsible for completing preventative actions. The form was signed by both RN C and RN E.

59. There was limited senior staff availability over the holiday period.

Further information

60. Oceania undertook an internal review of Mrs B's care. Oceania told HDC:

[23] Urine containing pus.
[24] The catheter was inserted at the public hospital.
[25] A sensation of pain felt when pressure is removed suddenly.
[26] Computed tomography — a scan used to show details of internal organs for diagnostic purposes.
[27] Death of part of the intestine owing to the blood supply being cut off.
[28] Intact skin with non-blanchable erythema (redness) — tissue does not turn white when pressure is applied.

"As an outcome of reviewing the report and the documents available, it is clear that we did not meet all the expectations of care for [Mrs B] and her family, in particular wound management and timely assessment and transfer of care. I wish to apologise sincerely to [Ms A] and family for these omissions."

61. Oceania stated that a number of corrective actions have been implemented at the rest home, including the following:

a) Education sessions on skin care and pressure injury were provided on two occasions.

b) A new Business and Care Manager and Clinical Manager have commenced employment.

c) There are now four-monthly regional Clinical Manager one-day forums, chaired by the Regional Clinical and Quality Manager. In this forum, new policy and forms are reviewed, changes to processes are discussed, and specialist presentations are given.

d) Oceania's national dietician has reviewed the nutrition and hydration policy and introduced the use of Cubitan.[29]

e) An eight-hour study day for healthcare assistants and registered nurses has been designed and is being rolled out. It is expected that every care staff member will attend this annually.

f) Oceania is in the process of choosing a vendor to implement a clinical IT system, which will provide more transparency nationally to the Clinical and Quality team that Oceania systems and processes are being followed by staff.

62. In addition, the pressure injury assessment and monitoring form and pressure injury care plan were updated, and the form now includes a checklist for pressure injury interventions, and acts as a prompt on appropriate actions.

Responses to provisional opinion

63. Ms A was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. Her comments have been considered and incorporated into this report where appropriate.

64. RN C, RN E, and Oceania were provided with an opportunity to respond to relevant sections of the provisional opinion. RN C and RN E made no submissions. Oceania's response has been incorporated into this report where appropriate.

[29] A nutritionally complete oral supplement that contains nutrients to promote wound healing.

Opinion: Oceania Care Company Limited — breach

65. Oceania has a responsibility to ensure that the rest home operates in a manner that provides its residents with services of an appropriate standard. Oceania needed to have in place adequate systems, policies, and procedures, and then ensure compliance with those policies and procedures so that the care provided to Mrs B was appropriate, and that any deviations from good care were identified and responded to.

Sacral pressure wounds

66. The progress notes on 11 Month5 state that Mrs B had a broken area of skin in the sacral region. RN F dressed the wound and completed a Wound Care Plan and Management sheet, along with a Wound Assessment and Monitoring form. No further assessments after that date were detailed on the Wound Assessment and Monitoring form, but the wound was noted to have healed by 25 Month5.

67. On 29 Month5, staff identified that Mrs B had a grade 2 pressure injury on her sacrum. RN G completed an Incident Report and a Wound Assessment and Monitoring form. It is unclear if or when the pressure injury resolved; however, updated assessments on 17 Month6 noted that there were "no wounds present".

68. On 19 Month6, a grade 2 sacral pressure injury (0.5cm x 0.5cm, with superficial depth) was documented. It was reassessed on 22, 25, and 29 Month6. On 6 Month7, the wound measured 4cm x 1.5cm and had turned necrotic. The fields for wound depth and percentage of necrosis were not completed. On 7 Month7, it had progressed to a stage 3 wound. From that date onward (with the exception of 10 and 11 Month7), daily entries were made in the wound assessment form.

69. By 22 Month7, Mrs B's sacral wound was 6cm x 3cm x 3.5cm, and was 45% necrotic. On 30 Month7, a swab was taken and the matter was escalated to the GP. At this stage it had become a stage 4 pressure injury. The wound was reviewed by the Clinical Manager on 31 Month7, and a referral to a wound specialist was made. In total, the wound was dressed for 29 days up until 3 Month8. Aside from a single entry on 19 Month6, no pain scores were recorded on the wound assessment forms.

70. Oceania's "Wound Management" policy stated that a short-term care plan should be used for simple wounds such as skin tears, and that a wound assessment should be undertaken for wounds requiring more extended management. The policy stipulated that pressure injuries should be reported on an incident reporting form, and that assessments of wounds should be documented on the Wound Assessment and Monitoring form at every dressing change, with size tracings or photographic observation. The policy further outlined that any changes to the treatment plan were to be documented on the Wound Care Plan and Management sheet, with a reason for the change in treatment. Any wound that showed no sign of improvement in a three-week period was to be referred to a wound care specialist or a GP.

71. Contrary to this policy, no incident reporting form was completed for Mrs B's broken area of skin on 11 Month5. A Wound Care Plan and Management sheet was not initiated for the grade 2 sacral pressure injury on 29 Month5, and no wound tracings or photographic observations could be found on Mrs B's file. Additionally, despite deterioration of the sacral wound from 19 Month6 onwards, GP input was not sought until 30 Month7 (after almost six weeks of deterioration).

72. My expert nursing advisor, RN Jan Grant, made a number of criticisms in relation to the standard of nursing assessments, wound management care, and related documentation — in particular:

- Nursing staff failed to take a proactive approach when the progress notes from Month5 showed that care staff had identified redness and broken areas on Mrs B's sacral area. In particular, wound care charts should have been commenced, and consideration should have been given to providing Mrs B with a pressure mattress at this time.
- The wound care charts that were commenced should have been completed accurately. There are ticks in columns but the charts lack detailed assessments. Assessments and forms were not filled in adequately enough to obtain accurate data from them.
- No wound care plan was documented on 19 Month5 when it was recorded that Mrs B had a stage 2 pressure area on her sacrum. It was not until 19 Month6 that another Wound Care Plan and Management sheet was completed.
- From mid-Month6 through to Month7, the wound was measured five times only (19 Month6, 6 Month7, 8 Month7, 15 Month7, and 22 Month7). On each occasion there had been a considerable deterioration in its condition. The clinical notes do not indicate a robust assessment, intervention plan, or evaluation of why the wound continued to deteriorate.
- No swabs of the wound were taken until 30 Month7, despite the deteriorating nature and increasing size of the wound.
- Clinical progress notes and wound care charts did not always match the clinical picture and Mrs B's needs.
- There is no evidence to show that nursing staff discussed Mrs B's wounds as a group, or sought management input or any other professional input until 30 Month7.

73. A referral to either a GP or a wound care specialist would have been appropriate when the wound first became necrotic and began increasing in size, particularly given Mrs B's multiple comorbidities and high risk of developing pressure areas. RN Grant stated that there was "a lack of systematic assessment, and evidence of poor clinical judgement on the part of the nurses doing the wound dressing". She considers this to have been a moderate to severe departure from accepted standards.

74. RN Grant also commented that the turn charts, which were filled out by healthcare assistants, varied in their consistency — at times they were filled in every 2–3 hours, and at other times there were only a couple of entries for the day.

75. I accept RN Grant's advice. I am very concerned by the deficiencies in the assessment, evaluation, and documentation of Mrs B's wounds, and the delay in seeking specialist input. I note that the wound assessment forms were not filled out comprehensively by staff — characteristics of the wound were described incompletely, measurements were recorded only once a week, and there were no documented pain scores on the form except on one occasion. I am critical that other than documenting the deterioration in Mrs B's sacral pressure injury, nursing staff did not act on their observations.

76. In my view, these deficiencies represent a lack of critical thinking on the part of nursing staff, and were not consistent with Oceania's policy or accepted nursing standards. I also consider that nursing staff ought to have identified from the turn chart that care staff were either not turning Mrs B at the required frequency, or not documenting their turns. Repositioning of residents is an important pressure injury prevention strategy, and would have also assisted in relieving the discomfort Mrs B experienced as a result of her sacral wound. In the absence of documentation, it would be unsafe to assume that turns were being undertaken, and should reinforce the need for follow-up.

Pain management

77. The last pain assessment was undertaken on 17 Month6. Although Mrs B's pain subsequently increased, analgesia was not given consistently. Mrs B's medications were changed on 30 Month7 to include morphine prior to wound care. Contrary to Oceania's "Pain management" policy, staff did not evaluate the effectiveness of the new pain regimen after administration. RN Grant advised that an up-to-date pain chart would have given an indication of Mrs B's pain and whether more analgesia was required. RN Grant considers this omission to have been a severe departure from accepted standards.

Bowel activity

78. It was not unusual for Mrs B to go three or four days without a bowel motion. Enemas were given on 30 Month6, 4 Month7, and 1 Month8 (after Mrs B's bowels had not opened for four or five days), but there were also other times where Mrs B's bowels had not opened after five days and no interventions occurred. Most notably, there are no documented actions in response to Mrs B's lack of bowel activity from 3 Month6 to 15 Month6 (12 days).

79. I am concerned that Mrs B's constipation was treated infrequently, and consider it unacceptable that the facility's registered nurses did not take action when she did not pass a bowel motion for 12 days. In my view, this shows poor oversight of Mrs B's needs.

Care leading up to hospital admission

80. Ms A stated that on 1 Month8 she raised concerns with RN D that Mrs B was pale, clammy, in pain, and had blue lips. Ms A stated that RN D took Mrs B's temperature, told her that it

was OK, and left the room. Ms A's concerns were not documented in Mrs B's progress notes, and RN D said that he had no recollection of his shift on that date.

81. Entries in Mrs B's progress notes on 1 and 2 Month8 refer to good intake, and, at other times, to poor eating and drinking. Food monitoring and fluid balance charts indicate either a decrease in consumption or inconsistent monitoring of intake. Mrs B's fluid output was not documented on the fluid balance charts.

82. At 10.15pm on 3 Month8, it is documented that Ms A had visited and raised concern that Mrs B was confused. According to this entry, nursing staff attempted to test Mrs B's urine but she was unable to provide a specimen. It is further recorded that Mrs B vomited up her bedtime medications except for the zopiclone. Mrs B's observations were in the normal range, aside from her temperature of 35.4°C. The time at which these observations were taken is not specified, but it was noted that Mrs B's temperature was 35°C at 9pm. At 1am on 4 Month8, a bureau nurse documented that Mrs B had vomited again, and continued to vomit when turned. It was also documented that her temperature was 35.2°C, and her abdomen was distended and rigid with some tenderness on palpation. At 5am, the bureau nurse recorded that Mrs B was complaining of lower abdominal pain, felt cold and clammy, and appeared slightly confused.

83. The bureau nurse also documented that she had spoken to RN C about admission to hospital, but was told to monitor Mrs B until the morning and then to reassess her. This account is disputed by RN C, who denies that the bureau nurse queried admission or mentioned Mrs B's vomiting episodes. At 6.30am, Mrs B was noted to have cyanosed lips and fingernails, was disorientated, and had a weak pulse. The bureau nurse recorded that Mrs B was to be transferred to the public hospital's ED for further assessment.

84. RN Grant advised that Mrs B's medical condition started to deteriorate from 1 Month8, and that the clinical symptoms she displayed in the days leading up to her hospital admission should have alerted staff that she was very unwell. In particular, RN Grant advised that Mrs B's symptoms, which included poor food and fluid intake, lack of urine output, vomiting with a distended/rigid abdomen, increasing confusion, and coldness and clamminess, ought to have signified to nursing staff that she was "in need of urgent care".

85. RN Grant noted that the fluid balance charts between 22 Month7 and 3 Month8 monitored Mrs B's fluid intake inconsistently, and did not monitor her fluid output. RN Grant advised that the failure to record Mrs B's fluid input/output accurately represents a moderate departure from the accepted standard of care.

86. RN Grant noted that the progress notes policy was not followed, and no short-term care plan was documented for Mrs B when she became acutely unwell. RN Grant advised that this represents a moderate departure from accepted standards, and stated that a short-term care plan would have provided direction to both nursing staff and healthcare assistants regarding the changing nature of Mrs B's condition.

87. RN Grant also commented that Mrs B was noted to have poor urine output. RN Grant advised that early testing of urine for a possible infection should be an integral part of assessing a patient whose general condition is deteriorating. She advised that in light of Mrs B's clinical picture, failing to do a urine test represents a moderate departure from accepted standards. I accept RN Grant's advice and am critical that nursing staff did not attempt to conduct a urine test earlier than 3 Month8, and that when Mrs B was unable to provide a specimen, staff did not make further attempts to obtain a specimen.

88. I note that medical input was not sought overnight on 3–4 Month8. RN Grant advised that nursing staff should have sought medical advice and treatment sooner, and that the failure to do so showed a lack of skilled judgement, particularly in light of the fact that Mrs B's condition had been deteriorating over a period of some days. RN Grant also stated that there was poor documentation of, and communication with, family members, and that staff should have followed up Mrs B's family concerns by completing a full nursing assessment and a short-term care plan.

89. I share RN Grant's view that the care provided to Mrs B over the holiday period departed from accepted standards.

90. I am also critical that Oceania was unable to identify the bureau nurse on the evening shift on 3 Month8. It is important that aged care facilities keep adequate records of their staff, including those who provide temporary cover.

Staffing

91. At the time of these events, the Business and Care Manager and the Clinical Manager worked from 8am–4.30pm, Monday to Friday. RN C and RN E alternated being on call after hours on a weekly basis. Additionally, the hospital wing, where Mrs B resided, had a registered nurse on duty 24 hours a day over three shifts.

92. RN C was on leave from 9 Month6 until 7 Month7, over which time RN E covered the Clinical Manager role.

93. There was limited senior staff availability over the holiday period.

94. RN Grant advised that overall staffing at the rest home was adequate, but the number of staff on afternoon and weekend shifts was limited with respect to registered nurses. She also noted that staff at a senior level were not replaced consistently to cover gaps in the roster when leave was taken. RN Grant acknowledged that RN E assumed some of RN C's duties in addition to her own duties in the month that RN C was on leave, but commented that RN C's role as a registered nurse on the roster does not appear to have been filled. RN Grant also noted that there was limited availability of senior nursing staff over the holiday period. RN Grant commented:

> "It is my opinion that a senior staff member should have been rostered to be on duty. This would have ensured some consistency and oversight for junior and casual staff. Although staffing is usually kept to a minimum over holiday periods, changing clinical

needs and emergencies continue to happen, and need to be dealt with in an appropriate and timely manner. Hence it is my opinion that due to a lack of consistency, low numbers of senior staff and a high work load, staff did not accurately follow up the clinical indicators which should have alerted them to the acute changes in [Mrs B's] condition."

95. I accept this advice. While I consider that individual staff are responsible for ensuring that the care they provide is consistent with accepted standards, the organisation also has a responsibility to support staff in the performance of their duties. This includes ensuring that there is adequate cover for staff who are on leave, and that there is an appropriate mix of experience.

Conclusion

96. The wound care provided to Mrs B was not of an acceptable standard, and did not comply with Oceania's policy on wound management. There was also a lack of compliance with Oceania's pain management policy, and poor documentation in respect of Mrs B's input and output. In my view, poor record-keeping and poor compliance with policies and procedures amongst multiple staff members is indicative of an environment that did not sufficiently support and assist staff in their duties. Oceania's rosters confirm low numbers of senior staff over the holiday period, and I consider that this is likely to have contributed to the deficiencies in care. Further, it is concerning that Mrs B's constipation was treated infrequently, and that medical attention was not sought when her condition deteriorated.

97. Overall, I consider that ultimately Oceania is responsible for the failures in wound care, pain assessment, documentation, treatment of Mrs B's constipation, and the delay in arranging medical input for Mrs B's deteriorating condition, as detailed above. I find that by failing to ensure that Mrs B received services with reasonable care and skill, Oceania Care Company Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights[30] during that period.

Opinion: RN C — adverse comment

Oversight of sacral pressure injury

98. A number of registered nurses were involved in dressing, evaluating, and completing documentation for Mrs B's sacral wounds from Month5 up to Month8, but no management input appears to have been sought prior to 31 Month7. RN Grant advised that the assessments and forms were not completed adequately, and that clinical oversight from management should have identified this issue.

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

99. RN C was the Clinical Manager at the rest home; however, she was on leave from 9 Month6 and did not return to work until 7 Month7. RN C told HDC that RN E covered her role during this period. RN C stated that the change in Mrs B's wound status was not handed over to her on her return, and that RN E continued to have control over key clinical responsibilities, such as wound care, weight control, and file audit. In contrast, RN E said that RN C resumed responsibility in all these areas on her return to work. RN E stated that there is no documented record of a handover, as generally handovers are verbal by nature.

100. I do not accept RN C's submission that clinical responsibilities such as wound care remained with RN E after her return from leave. I note that an incident reporting form for a pressure area on Mrs B's foot was completed on 16 Month7, and that it identified RN C as the person responsible for completing preventative actions. I also note that RN C reviewed Mrs B's sacral pressure injury on 31 Month7 and made a referral to a wound specialist nurse. In my view, this points towards RN C maintaining her responsibility of having oversight of clinical issues such as wound care.

101. While I am critical that there was not adequate clinical oversight to identify issues with the documentation and assessment of Mrs B's wounds, I am mindful that RN C was on leave for some of the period in which Mrs B's wounds deteriorated (Month5 to Month8), and it is unclear what handover was provided to RN C on her return. I also note that the registered nurses involved in Mrs B's wound care do not appear to have sought advice from management prior to 31 Month7.

Advice provided on the morning of 4 Month8

102. On the evening of 3 Month8, Mrs B vomited up her bedtime medications (except the zopiclone), and vomited further when turned. At 1am Mrs B's abdomen was noted to be distended and rigid. By 5am she was cold and clammy and appeared slightly confused. The bureau nurse then called RN C. There are two different versions of events regarding what was said during the telephone call.

103. According to the progress notes, the bureau nurse spoke to RN C about admission to hospital, but was told to monitor Mrs B until the morning and then reassess her condition.

104. RN C denies that the bureau nurse queried admission with her or mentioned that Mrs B had vomited more than once. RN C stated that she was informed that the observations were all within the normal range. She told HDC that she instructed the bureau nurse to monitor Mrs B and to contact her about any further concerns.

105. RN Grant advised that if the bureau nurse did describe Mrs B's vomiting episodes and her other symptoms, and was instructed by RN C to monitor Mrs B until the morning, then this would show "a lack of skilled judgement". However, RN Grant stated that if the bureau nurse indicated that Mrs B had vomited only once, and that Mrs B's observations were stable, then it was reasonable to advise the bureau nurse to monitor Mrs B.

106. I accept this advice, and would be extremely concerned if RN C had been given an accurate description of Mrs B's deterioration and did not recommend seeking medical advice and treatment. However, in light of the conflicting evidence and the time that has elapsed since the events in question, I am not able to make a factual finding on what was communicated to RN C on the morning of 4 Month8.

Opinion: RN E — adverse comment

Oversight of sacral pressure injury

107. RN E was the Business and Care Manager. As detailed above, she covered the Clinical Manager role when RN C was on leave from 9 Month6 until 7 Month7.

108. RN Grant advised that assessments and forms relating to Mrs B's wound care were not completed adequately, and that clinical oversight from management should have identified this issue. However, RN Grant also commented that RN C's role as a registered nurse does not appear to have been filled, and that "[o]ne month is quite some time to be without a Clinical Manager, particularly when staff numbers are tight under ordinary circumstances".

109. I agree. While I am critical that RN E did not have sufficient clinical oversight to identify issues with documentation and wound assessment during the period she was acting as the Clinical Manager, I am mindful that the registered nurses involved in Mrs B's wound care did not appear to have sought management input prior to 31 Month7.

Recommendations

110. I recommend that Oceania Care Company Limited provide a written apology to Mrs B's family for the failures outlined in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B's family.

111. The rest home was sold by Oceania Care Company Limited to another company. Accordingly, I recommend that Oceania Care Company Limited satisfy itself that the deficiencies in the care identified in this investigation are not of concern in other facilities operated by the company.

Follow-up actions

112. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

113. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the DHB, and it will be advised of Oceania Care Company Limited's name.

114. A copy of this report with details identifying the parties removed, except the expert who advised on this case, and Oceania Care Company Limited, will be sent to HealthCERT and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Jan Grant:

"I have been asked to provide an opinion on the care provided to [Mrs B].

I have no personal or professional conflict of interest in the case. My advice is based on a review of the documentation provided.

I have read and agreed to the Commissioner's guidelines.

I am a registered Nurse with over 30 years of experience in Aged and Community Care. In that time I have held a variety of roles. I have been Manager and Director of Nursing in aged care facilities and community care for 17 years. I have represented NZNO and the Aged Care sector on a number of national working parties. I have been involved in setting Standards for Practice for Gerontology Standards. I have been a clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My immediate past role was as Clinical Advisor/Rehabilitation Coordinator in the community. I am a designated assessor for ACC. I have post graduate qualifications in nursing and a Masters degree in management, with nursing ethics and research as a focus.

Background

[Mrs B] was admitted to [the rest home] [in] 2011. She was reassessed to Hospital level care on the 9th [Month7]. Information taken from [the public hospital's letter] lists [Mrs B's] medical diagnoses as:

PPM syncope secondary to AF in 2009
AF not warfarinised due to high falls risk
IHD
PVD — right femoral-popliteal bypass 2003
redo F-P bypass graft 2010.
Right knee amputation due to blocked graft 2011
Right neck of humerus # 2011
Previous Left Breast infiltrating ductal carcinoma
Previous CVA
Total thyroidectomy
Bilateral THJR
Hypertension
Dyslipidaemia
Osteoarthritis

The clinical notes reviewed by me, start from [date] and show that [Mrs B] required a standing hoist to transfer with two staff required to assist with this. [Mrs B] wore continence pads. She required the application of creams to her skin. Progress notes indicate she was eating well. By mid [date] [Mrs B] complained of a sore left shoulder. This continued for some months. Pain relief and topical anti-flam were given. On [date] she was seen by the Doctor, who charted oral anti-inflammatory medication. At this time [Mrs B] was seen regularly by the physiotherapist. In [date], [Mrs B] developed a cold and required inhalers. The doctor visited on [date] and charted antibiotics and a short course of frusemide. On [date] the progress notes indicate that [Mrs B] had a very dry, red left heel. She was also commenced on Prednisone for one week.

On [date], [Mrs B] was admitted to [the public hospital]. She returned back to the facility on [date]. On [date], a blister was noted on her left heel. Notes from the 2 [Month1] state '*[Mrs B] has small tear on her anal area: reported to EN and RN'.*

Throughout [Month1] and onwards, the progress notes indicate that [Mrs B] was a lot frailer and required extra care with skin integrity needs and with activities for daily living.

On the 19 [Month3] notes indicate that there was redness over the sacrum and that Menalind cream was applied. This was continued until 11 [Month5], when the entry states:

> '… on observation noticed broken area on sacral cleft and small hole filled with white scabs; cleaned and applied …'

From the 11 [Month5] till 29 [Month5] the notes indicate that Menalind cream was applied to sacrum/buttocks. On the 29 [Month5] the notes state that: '[Mrs B] has a stage 2 pressure area on sacrum L. size 1cm, D. 0.2cm. Dressing done. Incident form done. Family notified. No c/o pain. Wound care plan done.' This is signed by the registered nurse. The notes state that Menalind cream continued to be applied to the buttocks.

On 9 [Month7], a multidisciplinary meeting was held. It documents that cares were discussed with [Ms A] (daughter and EPOA) and that she was aware of [Mrs B's] pressure area care plan.

On 15 [Month7], notes indicate that the dressing was reviewed by [RN C] (the Clinical Manager). The advice was to debride and pack with what appears to be a honey dressing and something else which is hard to read.

On the 16 [Month7] it was reported that [Mrs B] had pain over her buttocks. A pressure area on the left heel was also identified at this time.

[Mrs B] was commenced on Paracodeine for pain in relation to her pressure area, and clinical notes show that this was given daily on average.

On the 30 [Month7], [Mrs B] was seen by the doctor and morphine was charted to be given prior to dressings to the sacral pressure area. This was discussed with [Mrs B's] daughter who was aware of this management.

[Mrs B's] daughter visited on [1 Month8] and again on the 3 [Month8]. She expressed concern about [Mrs B's] increased confusion. On the same day, the 3 [Month8], [Mrs B] vomited and complained of abdominal pain. Recordings showed that her temperature was 35 degrees C.

Overnight, [Mrs B] deteriorated and continued to vomit. Staff observed at 0100 hrs on the 4 [Month8] that her abdomen was quite distended, rigid and there was some tenderness on palpation. At 0500 hrs it was noted that [Mrs B] was cold, clammy and slightly confused. The clinical notes indicate that [RN C] (the Clinical Manager) was contacted and a decision was made to monitor until morning.

At 0630 hrs, [Mrs B's] condition deteriorated further. Her pulse was 70, but weak. At 0830 hrs on the 4 [Month8] notes indicate that [Mrs B] continued to be very unwell. At this point an ambulance was called and [Mrs B] was admitted to [the public hospital].

1. The appropriateness of the care provided to [Mrs B] leading up to her admission to [the public hospital]

The general discharge summary from [the public hospital], dated the 8 [Month8], states that [Mrs B] was an 87 year old woman admitted from Rest home with ? Ischaemic bowel/Bowel obstruction. The letter also lists her multiple co-morbidities.

It states that she had a history of distended painful abdomen over the previous day, and that she had been nauseated with vomiting of dark vomitus. On admission she presented as clinically dehydrated, with cloudy, purulent urine from an indwelling catheter, and a deep pressure sore over the sacrum, with slough. Her abdomen was described as distended, but soft, with pain to percussion and rebound tenderness in the left lower quadrant.

The decision was made that surgery would not be in her best interest, and also not what she would have wanted, and that a conservative management pathway with a palliative focus would be taken.

[Mrs B] passed away at 7.45am on 5 [Month8].

Reviewing the clinical notes for the week before admission, they show that [Mrs B] had 3 small bowel motions from the 23 [Month7] till the 29 [Month7] and a large bowel motion on the 1 [Month8].

The clinical progress notes show that from [25 Month7] onward [Mrs B] ate well at times but at other times ate poorly. She mostly rested on her bed. She was given pain relief inconsistently although it was charted four times a day.

27 [Month7] Paracodeine given at 11.30hrs, 17.30hrs

28 [Month7] 11.00hrs, 17.10hrs

29 [Month7] 12.15hrs

30 [Month7] 14.00hrs

Following the doctor's visit on the 30 [Month7], Paracetamol was charted four times a day and Morphine elixir to be given prior to wound dressings. Morphine was given twice on the 1 [Month8], twice on 2 [Month8] and once on the 3 [Month8]. (as per medication administration chart).

Lactulose was charted twice a day but from the documentation I received I am unable to assess if it was given as charted.

On the 31 [Month7], staff have reported no concerns. On the 1 [Month8] at 06.00hrs a microlax enema was given when staff noticed that bowels had not opened for 3 days. The bowel chart indicates that she had a large soft bowel motion on the morning shift.

Staff identified on the 2 [Month8] that [Mrs B] was eating and drinking poorly. On the 3 [Month8] staff have documented that [Mrs B] had good food and fluid intake and there were no concerns.

Later in the day she was visited by her daughter who expressed concerns that [Mrs B] was unwell and appeared to be more confused. She requested that staff do a dip stick to test [Mrs B's] urine. Later in the evening [Mrs B] vomited all medications. Her baseline recordings were done and apart from her temperature of 35.4°C were within normal limits. She vomited again at 20.30 hrs. Her temperature was rechecked and it was 35.0°C at this stage. Staff have documented that she appeared settled in her bed.

There is a note in the care notes asking staff to follow up on the results of the urine dipstick. On the night shift of 4 [Month8], on the first round at 0100hrs, it was noted that [Mrs B] had again vomited and that when turned she continued to vomit small amounts. Staff observed that her abdomen was quite distended and rigid. [Mrs B] was reported to be coherent and orientated, though a little 'vacant'. Her recordings at this time were oxygen saturation 95%, Pulse 69, Temp 35.2°C, BP 120/60 and resps 16. There had been no urine output. At 0500hrs [Mrs B] was reported to be in discomfort. At this time she felt cold and clammy and was observed to be slightly confused. She had not passed urine and her recordings were listed as stable.

The notes indicate that the nurse contacted [RN C] (roster lists a [RN C] as clinical manager) re possible admission. The decision was made to monitor until the morning and at that time to reassess the situation.

At 6.30am the notes state that [Mrs B's] condition had deteriorated further. It was reported that her lips were cyanosed and she was not recording a pulse oximeter reading. The decision was made to send [Mrs B] to hospital.

[Mrs B] was transferred to [the public hospital] at 0845hrs on 4 [Month8]. ([Ambulance service] summary).

She passed away at 7.45am on 5 [Month8].

Summary

I am of the opinion that the clinical symptoms that [Mrs B] displayed in the days leading up to her admission to hospital should have alerted staff that she was very unwell. The entries in the care progress notes in some way conflict with other entries and with what family identified on the 1 [Month8] when they spent the day with [Mrs B]. [Ms A] (daughter and EPOA) has identified that she found her mother to be confused, in pain and that her lips were blue. She reports that she was clammy to touch. She reported this to the RN who took [Mrs B's] temperature and informed the family that this was OK. However there is nothing documented in either the clinical notes or in the family communication report.

[Ms A] documented that she came back on the afternoon of the 3 [Month8] and found her mother to be much worse. At this time she requested staff do a urine test.

Clinical issues which should have been addressed.

Pain. The last pain assessment was undertaken on the 17 [Month 11]. Clinical notes show that [Mrs B's] pain increased. However, administration of analgesia appears to have been sporadic. Pain medications were adjusted on 30 [Month7], with regular qid paracetamol and morphine elixir prior to wound care. An up to date pain chart would have provided some indication of the extent of [Mrs B's] pain, whether more analgesia was needed throughout the day (eg prior to dressings to her pressure sore), and once a new pain relief regime was introduced, how effective it was in managing [Mrs B's] pain.

Short term care plan to accurately outline clinical needs. This would have provided information and direction to both registered nursing staff and health care assistants to the changing nature of [Mrs B's] general condition.

Medical Input. The Registered Nurses should have alerted medical staff as soon as [Mrs B's] condition changed. It is noted that the advice from [RN C] (roster shows her as the clinical manager) on the morning of the 4 [Month8] was to monitor until morning and then review. This advice, in my opinion, shows a lack of skilled

judgement. Medical advice and treatment should have been sought sooner, particularly as [Mrs B] had been progressively deteriorating over a period of some days, during which time family had expressed their grave concerns.

Accurate charting of fluid input and output. Despite a deteriorating general condition, observations of clinical dehydration, poor urine output to the point of no urine output towards the end of [Mrs B's] life, and evidence of constipation, there appears to have been no accurate monitoring of fluid balance i.e. fluid intake and urine output.

Assessment of probable urinary tract infection. [Mrs B] was noted to have poor urine output but there was no description of her urine which may have alerted staff to a probable urinary tract infection. This was brought to the staff's attention by [Mrs B's] daughter who requested a urine test. By the time [Mrs B] reached [the public hospital] her urine was described as purulent. Early testing of urine for possible infection should be an integral part of assessing a patient whose general condition is deteriorating.

Assessment of Bowel Activity. A daily bowel chart is a simple means of assessing for constipation, particularly if the patient is receiving medication such as codeine and morphine, with their well know side effect of causing constipation. This seems to have been reported sporadically and treated infrequently. Constipation may well have been one of a number of factors in the cause of [Mrs B's] vomiting and abdominal pain.

Accurate documentation of family requests and concerns. It is clear that family had become increasingly concerned re [Mrs B's] deteriorating condition and had discussed matters with staff on several occasions. However, there does not appear to have been appropriate action taken to meet these concerns, with poor documentation of follow up and communication with family members.

It is my opinion, from the documentation I have read, that [Mrs B's] medical condition started to deteriorate from [1 Month8]. Her family identified clinical issues with staff, and staff should have followed up these concerns by completing a full nursing assessment, with the development of a short term care plan to manage any issues identified.

I believe that there has been a severe departure from acceptable care and standards and it would be viewed as a severe departure by my peers.

2. The adequacy of [Mrs B's] wound care management leading up to her admission to [the public hospital]

Wound care is identified in a number of places in the clinical records, including:

Wound care plan and management sheets

Medical Notes

Wound care assessment forms

Care progress notes

Care plans and assessments

A referral to DHB wound care

Wound Management plans

The wound care management sheets include wound care documentation for pressure area [date], and relates to a pressure area on the L heel. It outlines the interventions, and goal evaluation. This is supported by a wound assessment form which lists the date the dressing is done, and a number of wound assessment details such as wound measurement, wound bed, exudate level, type of exudate, peri wound area, pain, and suspected infection. It has been signed by the registered nurse. It appears this wound healed on the 5 [Month3].

The second wound care plan and management sheet is commenced on the 11 [Month5]. It relates to the pressure ulcer and lists the location of the wound as being the sacrum. This form states the wound healed on the 25 [Month5]. There are no supporting entries on the wound management assessment form for this wound.

The third Wound Care Plan and Management sheet was not dated but lists the wound type as pressure area stage 3 and the location of the wound on the L buttock. There is no date on this form.

The fourth Wound Care Plan and Management sheet dated the 19 [Month6], lists the wound as pressure area stage 2 and the location as sacrum. Interventions are listed on the following dates: 25 [Month6], 28 [Month6], 15 [Month7] and 31 [Month7].

The wound assessment form is completed on the dates the dressings were done, starting from the 19 [Month6]. In total the wound was dressed for 29 days up until the 3 [Month8].

The wound appears to have been 0.5cm in length and 0.5cm in width and superficial in depth on the 19 [Month6]. By the 6 [Month7] it was 4cm in length, 1.5 cm in width, while no depth was listed at this time. Staff described the wound bed as being pink epithelial tissue until the 6 [Month7] when the presence of necrotic tissue and slough was recorded. There is no percentage listed on the wound chart.

The next documented measurement was on the 15 [Month7]. This lists the length as 5cm, width 3cm and depth and 2.5cm. It lists the necrotic tissue as being 25% of the wound.

The only other time wound measurement was done was on the 22 [Month7] when it had increased in size to 6cm in length, 3cm in width and 3.5 cm in depth. The necrotic tissue is listed as being 45% of the wound bed.

No swabs were taken of this wound despite the deteriorating nature and increasing size of the wound.

The medical notes for the 30 [Month7], show the doctor examined the pressure area and lists it as grade 4 with necrosis. It also notes the patient complains of discomfort and pain. The revised management plan is stated as debridement, with morphine to be administered prior to this. Dressings were to be done OD (once a day) and PRN (as required) and that this plan was explained to daughter.

Registered Nurses' Assessments

Registered Nurse Assessment Forms are included in the documentation. They are dated [2014], [2015] and 17 [Month6].

The form that is used and dated 17 [Month6] lists nine areas of possible assessment. The only areas that are ticked include:

1. Dry skin,

2. Red areas,

4. Scars/cuts,

5. Rashes

There is no detailed analysis of the ticked areas. No other information is listed.

Other assessments related to pressure areas are a Braden Risk Assessment which was completed on the 19 [Month6], giving a score of 13, which makes [Mrs B] at moderate risk of developing pressure areas. A Waterlow Pressure Assessment was completed [in 2015] and [2014]. Both of these assessments have defined [Mrs B] as being a high risk of developing pressure areas, but the most up to date one lists [Mrs B] as having moderate risk of pressure developing pressure areas.

Documentation also included Turn Charts to show how frequently staff turned [Mrs B], to change her position in bed. The dates relate to [Month1] onwards. They vary in their consistency. At times they are filled in 2–3 hourly and other times they are brief, with only a couple of entries for the day.

Care progress notes

Progress notes are written at least daily. Entries may be as frequent as twice daily and at times three times a day. They outline the cares and support given. The larger percentage of notes are written by health care assistants. Where the registered nurse has made an entry a designation is documented beside the signature.

In relation to the sacral pressure area, the first documentation is on the 26 [Month1]:

'Menalind cream to buttock very small area looking red'

29 [Month1] 'Menalind cream to buttock small broken area on buttock. Turn chart in her room needs two hourly turns during the night'

6 [Month3] '… Menalind to bottom small broken skin around sacrum, EN informed'

Other entries relate to cream to buttocks, with several entries noting that buttocks are red.

On the 11 [Month5] '… On observation noticed a broken area on sacral cleft small hole filled with white scabs, cleaned and applied hydrocoll Dressing'. (This was when the first wound chart for the pressure area was commenced.)

19 [Month5] '16.00 hrs. [Mrs B] has stage 2 pressure area on sacrum size L 1cm D 0.2cm dressing done. Wound care plan done'. No wound care plan was included in the documentation.

It was not until the 19 [Month6] that another wound care plan and management sheet was completed.

Care Plans

A number of Person Centred Care Plans are presented in the documentation. These care plans identify activities of daily living and document a desired goal and outcome. There is a section for documenting assessments and interventions to achieve goals. The three presented are dated [2014], [2015] and the 2 [Month7].

The section that relates to skin integrity is listed as Personal Hygiene/Skin/Pressure Relief.

The Person Centred Care plan was documented on the 2 [Month7].

The goal is listed as:

> '[Mrs B] will be provided with a high standard of cares with staff assistance to maintain good skin integrity, skin moisturised daily and no wounds/pressure areas for 6 months.'

It states that [Mrs B] is totally dependent for this. It is also listed that a short term care plan is documented as she has a stage 2 pressure area on the L buttock, is receiving frequent dressing changes and is being repositioned regularly, has a daily rest on bed after lunch, and food and fluid intake is being monitored.

An air mattress was implemented and 2 hourly turns started on the 18 [Month7]. Morphine was charted to be administered prior to dressings from the 2 [Month8].

Referral

A referral was sent to [the DHB] Outpatients Wound Care on the 31 [Month7]. The accompanying fax stated that it was grade 4 pressure area on the left buttock, and that although [the rest home] was using honey dressings, that the wound had increased in size and was getting deeper.

Family communication

Included in the notes is documentation in relation to communication with family. This includes an entry on the 29 [Month5] when the RN rang and spoke to [Ms A] ([Mrs B's] daughter and EPOA) about the sacral pressure area.

On the 30 [Month7] [Ms A] was present when the GP discussed wound management and pain relief.

On the 31 [Month7] there is documentation of a phone call with [Ms A] about pain relief and wound debridement. It states that [Ms A] was happy with this.

Summary

There is adequate documentation around wound care and assessment but this lacks a systematic approach to wound care and management. Clinical progress notes and wound care charts do not at times match the clinical picture and [Mrs B's] needs. Progress notes documented early on that care staff had identified redness and broken areas on [Mrs B's] sacral area. However it appears that the registered nursing staff have failed to initiate a proactive approach to this issue.

Wound care charts should have been commenced in [Month5] when the issue of pressure areas and skin integrity was first identified. [Mrs B] had multiple medical issues which put her at high risk of developing pressure areas. Consideration for a pressure mattress at this time would have been appropriate.

Wound charts should have been completed accurately. There are ticks in columns but no detailed assessments. From mid-[Month6] through [Month7], the wound was only measured four times and each time there had been a considerable deterioration in its condition. The clinical notes do not identify a robust assessment, intervention plan or evaluation of why there continued to be such deterioration. At no time was consideration given to swabbing the wound. No evidence was presented that nursing staff discussed as a group, sought management input or any other professional input up until the referral to wound care on the 30 [Month7].

A referral in my opinion would have been appropriate when the wound first became necrotic and began increasing in size, particularly taking into consideration [Mrs B's] many comorbidities that placed her in a high risk category. There does not appear to have been a discussion or a wider consultation, including the GP and wound care specialists, for the use of alternative wound care products.

I note the policy of the facility to include collaboration and a multi-disciplinary approach to wound management. The policy also includes wound assessment. As previously stated, no accurate assessment was undertaken, including recommendations from the policy in relation to wound tracing and photographic observation.

The policy also includes criteria for referral to wound care specialist or GP. As previously stated, this was not done.

I am of the opinion that there was a lack of systematic assessment, and evidence of poor clinical judgement on the part of the nurses doing the wound dressing. There does not appear to have been any clinical reasoning as to the possible reasons this wound deteriorated.

Communication with family was also, in my opinion, inadequate. The comment that [Mrs B's] daughter was happy with the plan is misleading as it does not appear that [Ms A] was informed of the considerable deterioration of the wound.

I am of the opinion that the registered nurses failed to meet the standard required under the Nursing Council Competencies for Practice. In particular:

> Domain Two: Management of Nursing Care
>
> Competency 2.1: Provides planned nursing care to achieve identified outcomes
>
> Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings
>
> Competency 2.3: Ensures documentation is accurate and maintains confidentiality of information
>
> Competency 2.6: Evaluates health consumer's progress towards expected outcomes in partnership with health consumers.

I am of the opinion that the departure from acceptable standards would be viewed as moderate to severe by my peers.

3. The adequacy of [Mrs B's] clinical management in light of the hospital findings of probable ischaemic bowel and bowel obstruction.

As stated in question one I believe that the clinical assessment and management of [Mrs B's] medical condition did not meet with acceptable standards and would be viewed by my peers as moderate to severe departure from acceptable standards.

4. Any other comments which you consider pertinent to make which has not been covered above.

In reviewing the clinical notes and the assessment tools that the facility uses I am of the opinion that assessments and forms are not filled in adequately enough to get accurate data from them.

This is especially relevant with respect to wound assessment as it is a useful tool for referral to specialist care. Clinical oversight from management should have identified that these forms and assessment tools were not filled in accurately.

Another example would be pain assessment charts. These charts are very valuable if used correctly and consistently by staff.

Also accurate fluid balance charts allow medical professionals and other staff to assess input as well as output. It is noted that at [the public hospital] [Mrs B's] urine was noted to be purulent, but there is limited to no mention of this in the clinical notes. There is no assessment of output in the notes apart from staff trying to get a urine sample. At times the clinical notes are hard to read with not all documentation being legible. Signatures and dates should be used on forms where stipulated.

I also believe Medical input should have been accessed well before it actually was, in relation to both the pressure area management and [Mrs B's] rapidly deteriorating medical condition.

Jan Grant "

The following further expert advice was received from RN Grant:

"**1. The appropriateness of [the rest home's] staffing levels from 1st [Month5] to 4 [Month8].**

I viewed a roster dated from 28 [Month4] until 3 [Month8].

The roster includes Hospital, Rest Home and Dementia Unit. Average numbers for the whole facility are around 42–44 patients in total.

The average numbers in the Rest Home are between 16–20 residents, in the Hospital between 12–15 patients, and in the Dementia Unit between 12–15 patients.

The staffing roster is completed on one A4 sheet of paper.

The Business and Care Manager works from 8.00am–4.30pm, Monday to Friday.

The Clinical Manager also works from 8.00am–4.30pm, Monday to Friday.

The Hospital has a Registered Nurse rostered on duty 24 hours per day over 3 shifts. There are three Care staff on the morning shift and two Care staff on the afternoon shift.

The Rest Home has an Enrolled Nurse on duty on the morning shift five days per week. For the other two days of the week there is a Senior Care Worker on the morning shift. There is also a Care Worker from 7.00am until 1.30pm. There is one Care Worker on duty on the afternoon shift and one Care Worker on the night shift.

The Dementia Unit has one Registered Nurse two/three mornings per week as well as two Care Workers on the morning shift — one until 1.30pm and the other until 3.30pm. There are two Care Workers on the afternoon shift, and another Care Worker on night shift in [the rest home].

In addition, there is an Activities Coordinator 5 days per week from 9.00am until 4.30pm, and a Physiotherapy Assistant from 1.30pm until 3.30pm Monday to Friday.

All the rosters show many changes. These are especially evident around [the holiday period].

My opinion of staffing numbers is as follows:

If the roster is followed and all staff, including Management and the Clinical Manager, are present then overall staffing would be adequate. However, I am of the opinion that the staffing number on an afternoon shift is limited, with respect to Registered Nurses. There appears to be only one Registered Nurse on the afternoon shifts from 4.30pm on, for the whole facility. This would include the Hospital, the Rest Home and the Dementia Unit. There is an average of a total 43 patients. At weekends, the number of senior staff is very limited, with one Registered Nurse for both the morning and afternoon shifts. [From] the 23rd [Month7] until the 3rd [Month8], there appears to be only two days when senior nursing staff were available. These days were the 30th and 31st [Month7] when [RN C] returned to work from her leave. The Business and Care Manager was on leave from the 25th [Month7], while the Clinical Manager was on leave from the 22nd [Month7] until the 30th [Month7].

2. The adequacy of [rest home] policies in relation to pain management, progress notes, pressure risk management, skin care and wound management.

Pain Management Policy:
The Pain Management Policy is one and a half pages long and has associated documents which were not supplied to me but include: Pain Assessment (Abbey Pain Scale), Pain monitoring Tool, Short Term Care Plan, PCCP and progress notes.

My overall opinion is the pain management policy is very brief but it does outline what staff are expected to do and which assessments are to be undertaken.

Adequate for use.

Progress Notes:
There is a three page policy outlining the requirements for documentation within the Hospital, Rest Home and the Dementia Unit.

The requirement for documentation in the Hospital wing is that staff write in the progress [notes] twice a day i.e. on the morning and the afternoon shifts.

Adequate for use.

Pressure Risk Management: One and half page document to be read in conjunction with other associated documents which were not viewed.

Adequate, although brief.

Skin Care and Wound Management: — Five page document with associated documents.

This policy appears adequate for use.

Comment on Policy Documents

I am of the opinion that when associated documents and assessment tools are used in often complex clinical situations such as pain and wound assessment and management, then an organisation has the responsibility of ensuring all registered staff are educated in the use of these associated documents.

3. The reasonableness of the care provided by [RN C] on 4 [Month8] based on [RN C's] account of events.

[RN C] stated that she was on leave for a number of days and this is supported by the roster. From the 21st [Month7] until the 3rd [Month8], the roster shows that [RN C] was on duty for four days [in Month7]. The Business and Care Manager was available from the 21st [Month7] until the 24th [Month7] and also on leave the week of the 28th [Month7]. The roster does show [RN E] (the Business and Care Manager) was on annual leave from Monday the 28th [Month7].

The roster also shows that many changes had been made and that there was not one consistent senior RN available over the holiday period.

On the [last two days of Month7] [RN C] was on duty with one RN in the hospital. She was not on duty on the 1st [Month8] but the roster shows she was on call on the 2nd and 3rd [Month8].

Following this there appears to have been only one RN on duty until the 4th [Month8] (that roster is not available).

[RN C] stated that she was contacted on the 4 [Month8] at 0500 hours and that the Registered Nurse did not relay the accurate details of [Mrs B's] condition. If the

Registered Nurse making the call indicated that [Mrs B] had vomited once, and that her recordings were stable, then in my opinion the advice that [RN C] gave would be acceptable and reasonable.

4. The level of oversight/involvement of the Clinical Manager in relation to Ms [Mrs B's] wound care.

It is my opinion that the Clinical Manager has overall responsibility for clinical issues. However, as Registered Nurses are on duty 24 hours per day then each RN must take responsibility for the care and service they provide on their shift. [RN C] has stated when she was on leave and obviously if she was not working then responsibility would fall to the staff who replaced her.

[RN C] states that she was on sick leave from the 9th [Month6] until the 7th [Month7] and this is supported by the rosters. It is also noted that she was replaced and her role covered during that time. [RN C] stated that [RN E] (the Business and Care Manager), had taken over her clinical responsibilities including wound care, weight control and file audits. [RN C] also states that [RN E] continued to have these responsibilities even after her return to work.

I am of the opinion that [RN C] cannot be held responsible if she was not at work due to sick leave or annual leave.

I am also of the opinion that the organisation must hold some responsibility as the roster shows staff at a senior level were not consistently replaced to cover gaps in the roster due to leave being taken.

5. Whether the additional information causes you to change any aspect of your initial advice to the Commissioner.

The additional information supplied by [RN C] shows when she was on leave from the facility. The Clinical Manager was not on duty from the 1st [Month8] hence the responsibility for care falls to the registered nurse on duty.

These facts do not alter in any way my opinion that the care did not meet an acceptable standard.

6. Any other matters that you consider warrant comment.

In relation to your initial advice, could you please outline

1. The clinical symptoms displayed by [Mrs B] leading up to her admission in hospital that you consider should have alerted staff to her unwellness.

As previously stated in my initial advice, I am of the opinion that the clinical symptoms that [Mrs B] displayed should have identified sooner, that she was very unwell and in need of urgent medical care.

Clinical signs which should have alerted staff include:

Poor food and fluid intake

No urine output

Continuing to vomit, with distended and rigid abdomen

Increasing confusion

Cold and Clammy

I would also like to make the comment that the family spoke to nursing staff on the 1st [Month8] and again on the 3rd [Month8] to express their concerns.

2. Your view regarding the severity of departure from expected standards in relation to:

Pain assessment: The last pain assessment was undertaken on 17 [Month6]. Medications were changed on [30 Month7]. There is limited evaluation and the Pain Policy was not followed. I view this as a severe departure from acceptable standards.

Short term care planning. There was no short term care plan documented for [Mrs B] when she became acutely unwell. The Progress Notes Policy was not followed. I view this as a moderate departure from acceptable standards.

The charting of fluid input and output. Documentation is inconsistent around food and fluid intake. Fluid balance charts were not completed. There was no in depth assessment of this undertaken. I view this as a moderate/severe departure from acceptable standards.

Assessment of probable urinary tract infection. Family requested a urine test but this was not initiated by staff. In addition there seems to have been no attempt by staff to investigate the family's concerns.

I view this as a moderate departure from acceptable standards.

Assessment of bowel activity: There is limited documentation around bowel movements. This is viewed as a moderate departure from acceptable standards.

Conclusion

Each individual departure from acceptable standards might be viewed as moderate to severe. However there are a number of these departures and collectively they indicate a severe departure from acceptable practice, as stated in my earlier advice.

3. Any systems issues you have identified in your review.

I believe that Registered Nurses should carry out full assessments when patients are reported to be unwell. In addition the Registered Nurse should document his/her findings and any actions taken.

In [Mrs B's] case this did not happen. It must also be noted that family expressed concerns on two separate occasions and identified clinical issues which appear to have not been fully investigated by nursing staff.

It appears when [RN C] was off sick for one month that the Business and Care Manager assumed some of her duties with respect to wound care, in addition to her own duties. However, [RN C's] role as an RN on the roster does not appear to have been filled. One month is quite some time to be without a Clinical Manager, particularly when staff numbers are tight under ordinary circumstances.

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

[Mrs B's] care, as previously stated, lacked systematic assessment and demonstrated poor clinical judgement. Rosters show a lack of consistency with staffing and it is unclear whether the staff were permanent staff or casual staff contracted in over the holiday period.

It is my opinion that a senior staff member should have been rostered to be on duty. This would have ensured some consistency and oversight for junior and casual staff. Although staffing is usually kept to a minimum over holiday periods, changing clinical needs and emergencies continue to happen, and need to be dealt with in an appropriate and timely manner. Hence it is my opinion that due to a lack of consistency, low numbers of senior staff and a high work load, staff did not accurately follow up the clinical indicators which should have alerted them to the acute changes in [Mrs B's] condition.

It is recommended that consideration be given to replacing senior staff when they are on leave for any prolonged time period."

The following additional advice was provided by RN Grant:

"I have read both my opinions and viewed the documents sent.

The bowel charts were completed twice a day, hence there is documentation on bowel movements and as such this would be seen as acceptable. I do not have the clinical notes but do note that there are days where no bowel movements were recorded such as from the [3–15 Month6] a total of 12 days. I am unable to say if interventions took place without viewing the clinical notes.

Fluid balance charts — My first two opinions stated that they were not completed and that this would be viewed as a severe departure from acceptable standards. I viewed what was provided and have revised my opinion.

The fluid balance charts show that fluid intake was collected from 22 [Month7] till the 3 [Month8] There are 4 days when fluid intake is shown for the whole day. The other charts show that there is inconsistent monitoring of intake. All charts show that there

was no monitoring of output. I still am of the opinion that the charts are inconsistent. If patients are on a fluid balance it is for the accurate recording of intake and output. On the whole the charts do not show this and I view this as a moderate departure from acceptable standards.

Assessment of urinary tract infection: In my first opinion I stated that [Mrs B] was noted to have poor urine output but there was no description of her urine which may have alerted staff to a probable urinary tract infection. This was brought to staff attention by [Mrs B's] daughter who requested a urine test. Staff did not do this and I believe that staff should have looked at the clinical picture and tested her urine. There are a number of tests and the simple dip stick test would have shown the possibility of an infection. This is a simple clinical task that a registered nurse can undertake, this does not have to be ordered by a doctor, and it's simply dipping a lab stick in urine and it will show a number of things including blood, nitrites and leukocytes which could have indicated a UTI. As stated by the time [Mrs B] got to hospital staff describe her urine as purulent.

I am of the view that this would be a moderate departure from acceptable standards."