HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Standard of care provided to multiple residents at care home

1. This Office received four complaints relating to the standard of care provided to residents with high and complex needs living at an aged residential care facility, Eileen Mary Residential Care and Retirement Village (the care facility), operated by Eileen Mary Age Care Limited[1] between 2022 and 2024. At the time of the events, the care facility was owned by Eileen Mary Age Care Limited. On 13 November 2024, the care facility was sold to new owners. The four complaints have been combined into a single investigation.

2. Although the facility continues to operate as 'Eileen Mary', ownership transferred to a new operator in November 2024. The complaints investigated here relate to historical events that occurred before that change. Since taking over in late 2024, the new operator reports that investment in care systems and staffing has improved the standard of care, occupancy, and resident satisfaction.

Information gathered

Mrs A

3. Mr A complained about the care provided to his late mother, Mrs A, in 2022. He stated that maggots had been found on her legs during a routine wound dressing change, and he requested that the Health and Disability Commissioner (HDC) review the care provided to her.

4. Mrs A, aged 94 years at the time, was admitted to the care facility on 21 January 2022 for hospital-level care after recent hospitalisation for exacerbation of congestive heart failure (CHF).[2] In addition to CHF, Mrs A had a history of dementia, leaking bilateral leg oedema,[3] and wounds on her legs caused by the leaking. Mrs A required extensive assistance with activities of daily living, including personal cares and mobility.

5. On admission, Mrs A's long-term care plan (LTCP) noted that she had very dry, fragile and itchy skin that was prone to breakdown. The LTCP also recorded that Mrs A had a stage one (superficial) pressure injury[4] on her left leg and that she needed support to prevent the risk of pressure injuries worsening.

6. A wound care plan was developed for a 'small open area' that was noted on the left lower leg on 23 January 2022. No photos or measurements of this wound were taken, as required by Eileen Mary Age Care Limited's Wound and Skin Care Management Policy (dated July 2024). Minutes of a Toolbox Talk (dated 20 May 2022) with Eileen Mary Age Care Limited

[1] Now known as EMAC 1 Limited.
[2] A chronic condition in which the heart is unable to pump enough blood to meet the body's needs.
[3] Swelling. Oedema is a common complication of heart failure.
[4] Localised damage to the skin, caused by pressure, friction or shearing forces. This is a preventable form of harm.

staff state that the care facility manager was to purchase a phone so that staff could take photos, which suggests that staff did not have equipment to take photos at the time of the events.

7. The wound care plan instructed staff to cover the wound with absorbent pads and to change the dressing every two days. The care plan also advised staff to check the dressing every shift and to replace the dressing if it was wet.

8. Clinical records show that the wounds were reviewed regularly, and on 9 February 2022 it is documented that the absorbent dressings needed to be covered with two layers during replacement. No other concerns were recorded until 20 February 2022.

9. On 20 February 2022, a nurse found maggots in Mrs A's left lower leg wound during a routine dressing change. The moisture levels and exudate level of the dressing prior to its change is not recorded. The nurse contacted the on-call care facility manager, who advised the nurse to wash the wound with warm water and Betadine,[5] which was completed. Hato Hone St John ambulance service was called for further support. The ambulance service assessed the wound and advised Eileen Mary Age Care Limited staff to follow up with the general practitioner (GP) the following day. A swab of the wound was taken to check for infection. No photos of the maggots or the wound were taken.

10. On 21 February 2022, Mrs A was assessed by the GP, who advised staff to continue Betadine washes, follow up to obtain the wound swab results to ensure there was no infection, and to review the wound if it deteriorated further.

11. An adverse event report was completed on 23 February 2022, which noted that fluid in Mrs A's wound may have attracted flies from a nearby sheep paddock during the warm weather and fly season. The family were informed of the adverse event. The adverse event report did not record the size, quantity, or a picture of the maggots. Clinical records note that Mrs A's neighbours had brought in fly spray and a portable fan to remove the flies from her room. No other pest control measures were implemented by Eileen Mary staff to manage the flies.

12. Sadly, Mrs A passed away after the complaint was made.

13. Mr A was given the opportunity to comment on the 'information gathered' section of the provisional report. He did not provide any comments.

<u>In-house clinical advice</u>

14. In-house clinical advice was sought from aged care advisor Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A). She noted the following:

- The wound care plan was acceptable. However, a dressing product with stronger absorbency could have been used, and if the bandage was left wet this would be a **mild** departure from the accepted standard of care.

[5] An antiseptic.

- The wound management policy and documentation of wound care — **mild to moderate** departure from the accepted standard of care.

15. In addition to the above, RN Johnson-Bogaerts advised that there were limited post-event remedial actions, a lack of earlier action on the presence of flies, and a lack of activation of pest-control measures.

Decision — adverse comment

16. I express my sincere condolences to Mr A and his family for Mrs A's passing.

17. Having reviewed the clinical records and response from Eileen Mary Age Care Limited, I am critical of the care provided to Mrs A by Eileen Mary Age Care Limited. I concur with RN Johnson-Bogaerts and consider that the wound management plan and the remedial actions in response to finding maggots was inadequate overall. Specifically, I am critical of the lack of pest-control measures implemented by Eileen Mary Age Care Limited, the standard of adverse event reporting, and the lack of compliance with the Wound and Skin Care Policy. I am concerned that Eileen Mary Age Care Limited considered that the care provided to Mrs A was appropriate.

18. I am also concerned to learn that Eileen Mary Age Care Limited placed reliance on Mrs A's neighbour to contain the pest, rather than actively taking the lead. In my opinion, Eileen Mary Age Care Limited failed to demonstrate the level of advocacy necessary to minimise the risk of further harm to Mrs A.

Ms B

19. HDC received a referral from the Coroner regarding the care provided to the late Ms B, who had passed away due to complications from advanced breast cancer. The Coroner stated that Ms B's GP, Dr G, at the local GP centre, raised concerns around the timely recognition of Ms B's breast changes and escalation of care by Eileen Mary Age Care Limited in 2023 and 2024.

20. Ms B, aged 64 years at the time, was admitted to the care facility on 1 May 2023 for hospital-level care. She had a history of right middle cerebral artery infarct[6] with left-sided weakness, anxiety, and intellectual disability with limited ability to communicate, and she was fully dependent on staff for undertaking activities of daily living. Eileen Mary Age Care Limited said that Ms B did not have a breast cancer diagnosis or a family history of breast cancer when she was admitted to its care home. In contrast, Health New Zealand | Te Whatu Ora (Health NZ) documentation shows that Ms B's family had a history of maternal breast cancer and a non-maternal history of other forms of cancer.

21. Ms B's LTCP states that she could not verbalise her pain levels and that she required paracetamol when she was calling out or appeared unsettled.

22. No non-verbal pain assessment tools, such as the Abbey Pain Scale,[7] were being used over the course of Ms B's admission, as required by Eileen Mary Age Care Limited's Pain

[6] A stroke.

[7] A tool designed to assess pain in individuals with cognitive impairment or in people who cannot verbalise their pain.

Management Policy (dated 2023) and the Adverse Health — Early Warning Policy (dated March 2023), which state that non-verbal assessments are to be used in residents who are unable to verbalise pain or in those who have cognitive impairment. However, progress notes make regular references to Ms B 'calling out', 'screaming', and being 'unsettled' and 'restless'. Progress notes show that Ms B experienced these behavioural symptoms almost daily over March and April 2024, which required administration of midazolam [8] and quetiapine.[9] Primary care notes on 2 May 2024 record that Ms B had been 'noted by staff to be agitated over recent weeks.' This was not escalated to Ms B's Nurse Practitioner (NP) or GP for review.

23. Ms B's LTCP states that she was at risk for skin breakdown and was at a moderate risk for developing a pressure injury. Eileen Mary Age Care Limited told HDC that skin assessments occur regularly for residents. Progress notes do not explicitly record whether skin assessments had been undertaken every shift; however, there are references to redness on Ms B's sacrum, left leg, and right arm and armpit, which suggests that skin checks did occur. The progress notes do not record whether the redness on the skin was assessed as a pressure injury. Monitoring charts also show that regular turns were being completed for pressure injury prevention.

24. Progress notes record that, on 25 April 2024, a caregiver noted a lump (which was intact) on Ms B's right breast. This was the first time breast changes had been recorded by Eileen Mary staff in the clinical records. The lump was escalated to a nurse, who added Ms B to the GP/NP list for a clinical review. The nurse did not assess the size of the lump or signs of any redness, swelling, or pain on palpation. There was no further documentation about the breast lump until 30 April 2024.

25. While Ms B was waiting for a review by the GP/NP, progress notes record that a small lesion (wound) had developed on the right breast on 30 April 2024. A nurse cleaned and dressed the lesion and noted another lump on the left breast. A wound care plan and an incident form were completed, and a photograph of the wound was taken, in accordance with Eileen Mary Age Care Limited's Wound and Skin Care Management policy. The wound care plan recorded the size of the wound and that there was mild exudate[10] but no moveable mass. No other assessment of the wound occurred. The nurse did not escalate the wound to a senior nurse or clinical manager for advice, and the nurse did not report changes in the breast to the GP/NP for review. Eileen Mary Age Care Limited did not provide any policies relating to escalation of care, despite HDC's request.

26. An NP review of the breast occurred on 2 May 2024. The NP recorded that Ms B had 'a hard at least 5cm by 4cm mass' on the right breast and 'approx[imately] 4cm × 2cm' mass on the left breast. The NP noted that this may have caused Ms B's overall deterioration in recent months and Ms B's recent agitation. Dr G told HDC that she is concerned that Ms B's wound had been present for longer than had been reported by staff. The NP referred Ms B to hospital for investigation of the breast lumps.

[8] A medication used as a sedative and a relaxant.
[9] An antipsychotic medication.
[10] Fluid that filters from the circulatory system into lesions or areas of inflammation.

27. The hospital diagnosed Ms B with advanced breast cancer, and Ms B returned to Eileen Mary on 6 May 2024 for palliative care. Progress notes show that hospice was contacted and that hospice input occurred. However, no end-of-life care plan was commenced by Eileen Mary Age Care Limited, as outlined in the Te Tāhū Hauora Health Quality & Safety Commission (HQSC) Frailty Care Guides (2023).[11] Eileen Mary said that staff discussed the palliative care plan with Ms B's family, who wished for her to receive comfort cares. However, details of the palliative care plan and discussions held with the family are not documented in the clinical records.

28. Sadly, Ms B passed away in May 2024.

29. Ms B's sister, Ms H, was given an opportunity to comment on the 'information gathered' section of the provisional report. Ms H felt that staff did not have the knowledge to look after people with special needs and was concerned about the end-of-life care provided to Ms B. She trusted them to care for her sister when she could not and is disappointed to hear what has happened. Ms H hopes that the care facility's standard of care will improve in the future.

In-house clinical advice

30. RN Jane Ferreira provided in-house clinical advice (Appendix B). She noted the following departures from accepted standards of care:

- Lack of recognition of concern and timely escalation of breast lump and lesion — **mild to moderate departure**.
- Lack of end-of-life care plan, lack of recognition and management of pain — **mild to moderate departure**.

Decision – breach

31. I express my sincere condolences to Ms B's family for her passing.

32. Having reviewed the clinical records and response from Eileen Mary Age Care Limited, I find that Eileen Mary Age Care Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights. I concur with RN Ferreira that there was a lack of timely recognition of the changes in Ms B's breast. In my opinion, Eileen Mary Age Care Limited staff did not utilise critical thinking to establish the underlying reasons for the acute changes in Ms B's health. Had appropriate and holistic assessments of Ms B's ongoing pain and behavioural changes occurred in conjunction with the changes in her breast, her care may have been escalated to the GP/NP earlier. I am also critical of the lack of an end-of-life care plan to support the last days of Ms B's life.

33. I take this opportunity to remind Eileen Mary Age Care Limited of the immense trust placed on healthcare providers by vulnerable residents such as Ms B, and their families, to care for and advocate for their wellbeing.

[11] Care during the last days of life | Pairuri (palliative care) (Frailty care guides 2023) | Te Tāhū Hauora Health Quality & Safety Commission

Mrs D

34. HDC received a complaint from Ms C regarding the care provided to her late mother, Mrs D, by Eileen Mary Age Care Limited in 2022. Ms C raised concerns around the admission process, lack of communication from staff, pain management, and wound care.

Admission

35. Mrs D, aged 94 years at the time, was admitted to the care facility on 21 October 2022 for short-term care. Mrs D was transferred from hospital, where she had received care for a large pressure injury on her hip and buttock, increasing frailty, reduced mobility, and a urinary tract infection. Prior to her hospitalisation, Mrs D had lived at home with her husband and received regular support services. Hospital records show that Mrs D was awaiting a needs assessment to determine the suitability of her returning home. Mrs D had a history of advanced dementia and poor oral intake, and she required full assistance with activities of daily living.

36. Eileen Mary Age Care Limited's Admission Policy and Procedures document (undated) states that the resident or their representative is to sign an Admission Agreement within 10 working days of the admission and ideally on the day of the admission. Ms C was Mrs D's activated Enduring Power of Attorney (EPOA) for personal care and welfare. The Admission Agreement was signed on 25 October 2022 by Mrs D, and Eileen Mary Age Care Limited said that two nurses were involved in this process. Ms C told HDC that Mrs D was asked to sign her Admission Agreement despite having dementia and not having the capacity to understand the information written in the agreement. Eileen Mary Age Care Limited acknowledged that it did not follow due process and indicated that this had occurred because there was confusion around the status of EPOA activation. Eileen Mary Age Care Limited apologised to Ms C for this experience.

37. Progress notes do not record any discussions held with the EPOA regarding the admission process, such as the resident's expectations and needs, and the complaints process, as required by the Admission Policy and Procedures document.

38. The Admission Policy and Procedures document states that a GP/NP must be notified of any new admissions into the care home and must complete an examination and initial consultation with the resident within two working days of the admission. Clinical records do not show that a medical admission occurred. Eileen Mary Age Care Limited said that Mrs D remained under the care of her own GP, who was responsible for her prescriptions and charting of medications. However, Eileen Mary Age Care Limited also said that there are no records of a virtual or telephone consultation being held with Mrs D's GP. GP records show that Eileen Mary Age Care Limited staff made only one contact with the GP, on 9 November 2022 regarding Mrs D's constipation.

39. The Admission Policy and Procedures document states that a nurse must complete an initial comprehensive assessment on admission to determine the presence of an acute illness and define the initial care planning, including signs and symptoms monitoring, and reporting processes. An initial care plan was started, which noted Mrs D's mobility, skin care and self-care, sleeping, and sensory and communication needs. A pressure injury risk assessment was completed on admission, which noted that Mrs D was at a high risk for developing

pressure areas. However, an LTCP was never commenced, which is required by Eileen Mary Age Care Limited's Clinical Documentation and Report Writing Policy (dated March 2023). Eileen Mary Age Care Limited acknowledged that an LTCP should have been developed.

40. The first progress note entry on 21 October 2022 recorded that Mrs D had been admitted with a 'dressing [on the] left hip'. However, no wound assessment, pain assessment, or short-term care plan (STCP) for the wound were commenced, as required by the Clinical Documentation and Report Writing policy. Turn charts also did not commence until 12 November 2022.

41. Progress notes record that Mrs D 'complained [of] pain while moving'. No Abbey Pain Assessments, STCP, or pain management care plan were completed for Mrs D's pain, as required by Eileen Mary Age Care Limited's Pain Management policy and the Clinical Documentation and Report Writing policy.

42. A continence assessment was completed on 21 October 2022, which noted that Mrs D required assistance with her urinary and faecal incontinence. Mrs D also had a urinary catheter and experienced faecal incontinence and constipation (requiring manual evacuation[12]), but bowel and bladder function monitoring charts were not commenced. An internal audit report completed by Eileen Mary Age Care Limited (dated March 2023) found inconsistencies in the completion of monitoring charts.

43. A nutritional assessment was completed, which noted Mrs D's nutritional requirements, her history of weight loss, and her risk for malnutrition. No discussions were held with the family about Mrs D's nutritional needs and food preferences. Mrs D was on a nutritional supplement and had poor food intake. However, monitoring charts for food and fluid intake were not commenced.

Wound care

44. In November 2022, Mrs D passed away as a result of sepsis[13] from her infected pressure injuries. Ms C is concerned about the standard of wound care provided to Mrs D and told HDC that Mrs D did not have an infection when she was initially admitted to the care facility.

45. The Wound and Skin Care Management Policy notes that a skin integrity check must occur on admission. The policy states that when a resident presents with a wound, a description of the area and the treatment required for the wound must be documented in the progress notes. A nurse is to assess the wound and develop a wound management plan on the day the wound is identified.

46. A wound care plan was developed and commenced for Mrs D's sacral pressure injury on 12 November 2022 (22 days after admission). Eileen Mary Age Care Limited acknowledged that there was an unacceptable delay in commencing a wound care plan. The wound care plan noted that this was a stage 1 pressure area and that there were no breaks in the skin. A

[12] A procedure in which a finger is inserted into the rectum to remove stool from the bowel.
[13] A life-threatening condition that occurs as a result of the body's response to an infection.

photograph was taken, which shows reddened sacral skin with no breaks. The next wound review/dressing change was listed for 19 November 2022 (one week later).

47. The wound was reviewed again on 16 November 2022 (four days after the initial review and before the next dressing change was due). The sacral pressure injury had developed necrotic[14] tissue and was sloughy.[15] A photograph shows that the entire wound was black with reddened flaky edges. The wound was debrided[16] and cleaned, and the next wound review/dressing change was listed for 19 November 2022. Eileen Mary Age Care Limited accepted that the wound care plan and the dressing regimen was inadequate given the severity of the wound. Eileen Mary Age Care Limited acknowledged that the dressing should have been changed more frequently.

48. Eileen Mary Age Care Limited stated that a district nurse was contacted regarding the wound, and Eileen Mary Age Care Limited staff were advised that it was the responsibility of its staff to manage the wound. Eileen Mary Age Care Limited has no copy of any referrals completed to the district nurse, and the progress notes do not indicate that this occurred.

49. Eileen Mary Age Care Limited's Wound and Skin Care Management Policy states that, if the wound healing is prolonged or if there are signs of infection, the resident's GP/NP must be consulted to review the wound and advise on further treatment. However, the GP/NP was never consulted regarding the wound.

Acute deterioration

50. Progress notes show that Mrs D had reduced food and fluid intake from 16 November 2022 and that she either declined meals or ate a minimal amount. Eileen Mary Age Care Limited acknowledged that no STCP was developed to monitor Mrs D's weight or changing appetite levels. Eileen Mary Age Care Limited also acknowledged that these changes could have been an indicator of Mrs D's deteriorating health, and staff could have consulted with the GP/NP regarding these matters. Mrs D's family were not contacted regarding the changes in her food and fluid intake.

51. In the early hours in mid-November 2022, Mrs D deteriorated. Progress notes record that she appeared pale, had a rapid respiratory rate (24 breaths per minute),[17] poor oxygenation levels (78%),[18] and a rapid heart rate (120 beats per minute).[19] The nurse caring for Mrs D contacted the clinical nurse lead and the family to update them. Thereafter, an ambulance was called.

52. The ambulance service's entry into the care facility was delayed for 30 minutes because no access to the care facility was provided. Eileen Mary Age Care Limited said that its expectation is that someone would monitor the care facility entry to allow external services to access the resident promptly. Eileen Mary Age Care Limited acknowledged that this did

[14] Dead.
[15] Containing dead tissue.
[16] Dead/infected tissue was removed to promote healing.
[17] The accepted respiratory rate in adults is around 12–16 breaths per minute.
[18] The accepted oxygenation level is typically above 95%.
[19] The accepted heart rate in adults is typically 60–90 beats per minute.

not occur and that this delayed Mrs D's care by the ambulance service and her transfer to hospital.

53. Documentation from the ambulance service indicates that, on arrival, there were concerns about the care provided by Eileen Mary Age Care Limited. The ambulance service advised Eileen Mary Age Care Limited staff to administer oxygen to Mrs D because of her low oxygenation levels. However, the nurse caring for Mrs D refused to initiate this intervention as oxygen had not been prescribed. Eileen Mary Age Care Limited said that the nurse had consulted the clinical nurse lead, who had instructed the nurse not to administer oxygen. This resulted in the ambulance staff forcibly insisting that oxygen be administered. Eileen Mary Age Care Limited acknowledged that this was not acceptable and that nursing staff clearly required additional education around the use of emergency medicines.

54. Documentation from the ambulance service also indicated that there was poor handover from Eileen Mary staff to the ambulance service. It is documented that Eileen Mary Age Care Limited staff were unable to tell the ambulance service when the wound dressing had been changed. It is noted that the dressing was 'old', 'tattered at the edges and in parts not even stuck to skin', 'weepy', and 'pungent', and that the wound appeared necrotic. The ambulance service noted that Mrs D was significantly emaciated, with a reduced Glasgow Coma Score (GCS).[20] Eileen Mary Age Care Limited staff told the ambulance service that Mrs D had always had a reduced GCS. In contrast, Ms C told HDC that Mrs D had been 'very bright, [a]lert, and bubbly' on admission. Eileen Mary Age Care Limited documentation does not show that a GCS was recorded during Mrs D's admission.

55. Mrs D was transferred to hospital shortly after ambulance staff had assessed her. On arrival at the hospital, staff noted that Mrs D had a necrotic wound and sepsis. Comfort cares were initiated and, sadly, she passed away in mid-November 2022.

56. Ms C is concerned about the delays in Eileen Mary Age Care Limited staff in informing her that Mrs D had been 'actively dying'. Ms C said that she was informed only when Mrs D had deteriorated in the early hours. Ms C stated that the lack of communication meant that her family were unable to spend time with Mrs D before she died. Eileen Mary Age Care Limited said it is regretful that Mrs D's family were contacted about Mrs D's deterioration only in the early hours of the day she died, and it acknowledged that the communication with Mrs D's family was unsatisfactory.

57. Eileen Mary Age Care Limited acknowledged that the care provided to Mrs D was not of the standard it expected. Eileen Mary Age Care Limited apologised to Ms C for the care provided to Mrs D.

58. Ms C was given an opportunity to respond to the 'information gathered' section of the provisional report. Ms C said she was disappointed and angry that a home entrusted with her mother's care treated her poorly.

[20] A tool for assessing a person's level of consciousness.

In-house clinical advice (Appendix C)

59. RN Ferreira noted cumulative **moderate to severe** departures from the accepted standards of care due to Eileen Mary Age Care Limited's lack of compliance against its admission process, the standard of communication with Mrs D's EPOA, the lack of escalation of care to the GP/NP, the standard of wound management, and the lack of recognition of Mrs D's health changes and decline.

Decision – breach

60. I express my sincere condolences to Ms C and her family for Mrs D's passing.

61. Having reviewed the clinical records and response from Eileen Mary Age Care Limited, I find that Eileen Mary Age Care Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights. I agree with RN Ferreira that the necessary admission processes were not followed, that the wound management was substandard, that communication with Mrs D's EPOA was poor, and that the management of Mrs D's acute deterioration in November 2022 was inadequate, and I am critical of these failings by Eileen Mary Age Care Limited.

62. In my opinion, it is clear that Mrs D was deteriorating in the days following her presentation on 16 November 2022. This should have been managed through careful monitoring, holistic assessment of Mrs D's symptoms, an active partnership with Mrs D's GP/NP, including ensuring that a medical assessment occurred on admission, and greater oversight of the wound management processes.

Mrs E

63. Dr G, GP, made a complaint to HDC stating that clinicians at the local GP centre (as her registered practice) were not alerted to Mrs E's unstageable pressure injury[21] in 2023 and 2024.

64. Mrs E, aged 83 years at the time, was admitted to the care facility on 5 August 2022 for hospital-level care. Mrs E had multiple comorbidities, including dementia and diabetes mellitus. A Braden pressure injury risk assessment completed on 12 December 2023 showed that Mrs E was at a high risk for developing pressure areas.

65. Eileen Mary Age Care Limited said that a pressure injury was first noted on Mrs E's sacrum on 20 August 2023. This was graded as a stage one pressure injury, and the family was notified. Eileen Mary said that an STCP, an alternating air mattress, and a regular turning schedule were put in place to minimise the risk of the pressure area declining. Eileen Mary Age Care Limited said that these interventions were discontinued on 14 September 2023 as the area had improved.

66. Eileen Mary Age Care Limited said that a further stage one pressure injury was identified on the sacral area on 4 December 2023, and this deteriorated to a stage two[22] pressure injury within three days (on 7 December 2023). The family was updated regarding the wound on

[21] A pressure injury that is compressed for an extended period, leading to necrotic tissue. This is classed as unstageable because the full extent of the tissue damage cannot be assessed and it is difficult to determine the depth of the injury.
[22] Partial thickness skin loss.

4 December 2023, but no wound management plan or STCP was commenced until 7 December 2023. An incident form for this was completed on 7 December 2023. The HQSC Frailty Care Guides state that support should be sought from a GP/NP when there are signs of wound decline. However, this did not occur on 7 December 2023, when Eileen Mary Age Care Limited said the wound deteriorated.

67. Clinical records show that an air mattress and a pressure-relieving cushion were implemented, and regular turns were completed. These interventions received oversight from the care facility manager at the time. However, Mrs E's LTCP was not updated to reflect the wound care requirements. A further incident form completed on 19 December 2023 noted that the wound was not healing and was unstageable.

68. The HQSC Frailty Care Guides state that support should be sought from a GP/NP and a wound specialist for unstageable pressure injuries. There is conflicting evidence as to when a GP/NP was first notified when the pressure injury became unstageable. An incident form dated 19 December 2023 noted that an 'ISBAR[23] [form] and photo [were] sent to [the medical centre]'. Eileen Mary Age Care Limited confirmed that this occurred; however, a copy of the ISBAR form and communication records with the medical centre were not provided to HDC. Eileen Mary Age Care Limited said that the GP commenced Mrs E on antibiotics for suspected infection; however, the medication records provided to HDC do not show that antibiotics were prescribed. The GP centre's clinical records show that, on 11 January 2024, NP I recorded that Mrs E had a pressure injury that was either a stage four[24] or unstageable. NP I recorded that a nurse 'report[ed] [that the pressure injury] ha[d] only been present for [three] days [but it was] unlikely to be only that time'. This suggests that the medical centre may not have received any correspondence on 19 December 2023, possibly because of the Christmas/new year period.

69. Eileen Mary Age Care Limited said that the pressure area failed to improve despite the antibiotics, so it sent referrals to the dietician and specialist wound care services. A wound specialist referral was sent on 20 December 2023 and written advice on wound management was provided to the care facility on 12 January 2024, with instructions to contact the wound specialist services if the wound did not improve in two to three weeks.

70. A dietician referral was completed on 18 January 2024, and the dietician completed an assessment on 13 February 2024. Mrs E's diet was changed to assist with the healing of the wound. Eileen Mary Age Care Limited said that the wound improved following these interventions. A review by the wound specialist nurse on 9 May 2024 noted that the pressure area, now a stage three,[25] 'ha[d] improved significantly … and [was] healing well'.

71. Progress notes refer to pain assessments having been completed, and the medical centre's clinical records indicate that requests were made for additional pain relief to be charted for

[23] A framework for communicating information in a clear, contextualised, and collaborative way.
[24] A pressure injury that extends below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments. This is the most serious stage.
[25] Pressure injury that involves full thickness skin loss and may extend into the subcutaneous tissue. The wound does not expose muscle, tendon, or bone.

Mrs E. However, a non-verbal pain assessment tool was not used, as required by Eileen Mary Age Care Limited's Pain Management policy, until February 2024.

72. Sadly, Mrs E passed away in August 2024 after this complaint was received.

In-house clinical advice (Appendix D)

73. RN Ferreira advised that there were cumulative **mild to moderate** departures from the accepted standards of care in relation to Mrs E's pressure area management, the standard of communication with the NP/GP, and documentation practices.

Decision – adverse comment

74. I express my sincere condolences to Mrs E's family for her passing.

75. Having reviewed all the available information, I agree with RN Ferreira that there are several areas of concern with respect to the pressure area cares provided to Mrs E, the standard of communication with the NP/GP, and documentation practices. In my opinion, earlier support could have been sought from the NP/GP in relation to Mrs E's pressure area, given that there were clear indications that her wound was not healing. This was particularly necessary in light of Mrs E's history of diabetes, which is known to affect wound healing, and her high risk for developing pressure areas, as was noted during admission.

76. However, it does appear that, overall, Eileen Mary Age Care Limited provided regular and consistent pressure injury preventive care and gained appropriate support from the wound specialist and dietician services for Mrs E.

77. In my opinion, there are also opportunities for improvement with respect to the pain management practices. Although progress notes show that signs of pain were being monitored, this should have been assessed using a formal pain assessment tool, as is required by Eileen Mary Age Care Limited's Pain Management Policy.

Mrs F

78. Dr G, GP at the local GP centre, complained about the care provided to Mrs F. Dr G is concerned about the standard of wound care provided to Mrs F and the lack of documentation with respect to the wound care in 2023 and 2024.

79. Mrs F, aged in her 80s at the time, was admitted to the care facility on 17 August 2017, initially for rest-home level care but was then transitioned to hospital-level care in February 2023. She had multiple comorbidities, including Paget's disease[26] of the vulva, which required treatment with topical ointments. Eileen Mary Age Care Limited said that the Paget's disease was not problematic for Mrs F until 2020, when her symptoms appeared to flare up. Eileen Mary Age Care Limited stated that Mrs F then had persistent ongoing issues with pain and rashes related to the Paget's disease. Eileen Mary Age Care Limited also said that Mrs F had a temporary indwelling catheter to reduce irritation and pain around the genitalia associated with urinary incontinence. In addition, caregivers avoided using soap

[26] A rare skin cancer that affects the top layers of the skin. It presents as red raised patches on the skin that can be painful and itchy.

products on the genitalia and implemented a regular toileting schedule and other hygiene measures to minimise the risk of irritation and skin breakdown.

80. Mrs F's LTCP records that she had a rash on her vulva. The LTCP instructs staff to monitor her skin integrity during personal cares and to report to a nurse any concerns such as vaginal/vulval redness, skin breaks, bruises, and pain. The LTCP also instructs staff to apply topical ointments to the affected area. A wound care plan and an STCP were not developed in relation to the Paget's disease rash. Eileen Mary Age Care Limited said that as Paget's disease is a long-term skin condition, a specific wound care plan was not required. Eileen Mary Age Care Limited's Wound and Skin Care Management policy states that all wounds, including chronic wounds and skin treatments, are required to be documented in the clinical records.

81. Eileen Mary Age Care Limited said that the resident's skin integrity is monitored in the general care reporting/handover documentation, and this is the accepted practice across the aged residential care sector. However, progress notes do not always record skin checks as having been completed every shift or what care had been provided in relation to the Paget's disease rash.

82. Eileen Mary Age Care Limited said that, from 2023, Mrs F was reviewed by the GP/NP on at least 26 occasions for vaginal pain related to the Paget's disease. On 17 May 2024, the GP/NP recorded: '[A nurse is] to check the area daily for skin breakdown and advise if [there is] change from redness to worsening skin.' On 25 July 2024, the GP/NP recorded: '[Registered nurses are] to apply [topical treatments] NOT caregivers!!!', suggesting that nurses may not have been providing oversight of the rash.

83. No STCP was commenced, and the progress notes do not record any assessments completed by nurses, as instructed by the GP/NP. Progress notes show that caregivers escalated issues relating to the rash to nurses but do not show the actions taken by nurses in response. Eileen Mary Age Care Limited stated that a HealthCERT surveillance audit identified a lack of information regarding the management and appearance of Mrs F's rash and Paget's disease in the progress notes. Eileen Mary Age Care Limited acknowledged that the documentation in Mrs F's case was insufficient.

84. As noted above, Mrs F had ongoing issues with pain. The LTCP indicates that Mrs F wished to be pain free. Her medication prescription shows that she was receiving regular paracetamol and codeine (strong pain relief). The codeine was prescribed under the 'as required' section, but medication administration records show that she was receiving regular doses. Eileen Mary Age Care Limited said that staff relied on Mrs F to self-report her pain levels. No pain management plan was started to manage her ongoing pain. The medication administration records show that pain scores were calculated before pain relief was administered. The presence or absence of pain was recorded in the progress notes, but the efficacy of the pain relief was not always recorded, as acknowledged by Eileen Mary Age Care Limited. In addition, codeine is known to cause constipation. However, the clinical records do not show whether Mrs F's bowels were monitored and whether she was experiencing constipation.

In-house clinical advice (Appendix E)

85. RN Ferreira noted the following departures from the accepted standards of care:

- Standard of documentation in relation to wound/skin care with respect to vaginal rash — **mild departures**.
- Standard of pain management — **mild to moderate departure**.
- Standard of overall documentation — **mild departure**.

86. In addition to the above, RN Ferreira criticised the lack of documentation around the monitoring of CHF and weight recordings.

Decision – adverse comment

87. Having reviewed all the available information, I agree with RN Ferreira that there are several areas of concern in the care provided to Mrs F. I am concerned that Eileen Mary Age Care Limited did not consider that a wound care plan is required for chronic skin conditions. In my opinion, Mrs F's known skin condition required ongoing monitoring and frequent intervention. This warranted a dedicated management plan and consistent oversight from a nurse.

88. While it is evident that care was occurring and that staff were responsive to Mrs F's ongoing discomfort, I am concerned about the standard of documentation undertaken by staff with respect to the Paget's disease and Mrs F's pain levels. It is clear that Mrs F experienced regular episodes of discomfort, and it is my opinion that more thorough documentation of the characteristics of her symptoms would have better supported the assessments undertaken by clinicians at the local GP centre.

Response from providers

89. Eileen Mary Age Care Limited was provided with a full copy of the provisional report and given the opportunity to comment. It accepted the findings in the provisional report and extends its sincere apologies to the residents and families affected. It acknowledged the need for wound care plans for chronic skin conditions, documentation of dedicated management plans, and consistent oversight of residents by RNs.

90. Eileen Mary Age Care Limited said that recruiting experienced staff remains a persistent challenge and that this made the ability to provide a high standard of care more difficult at the time. Although it continues to support the development of clinical managers, sustaining leadership within complex care environments is also a challenge. Eileen Mary Age Care Limited said that these issues highlighted a need for sector-wide strategies to strengthen leadership capability and workforce resilience in aged care.

91. The new operator of the care facility was provided with a full copy of the provisional report and given the opportunity to comment. The new operator did not wish to make any comments as they were not the operator of the care facility at the time of the events.

Changes made

92. Eileen Mary Age Care Limited said that it has made the following changes since 13 November 2024:

- Staff have undertaken education on wound assessment and management; pressure injury management; the role of the EPOA, including how they are activated; hydration and nutrition; the admission process; open disclosure; effective communication, including with families and external services; pain management; transferring residents to hospital; end-of-life care; and the use of emergency medication.
- The handover process has been refined so that all wounds are mentioned during nursing handovers. Full handovers are also provided to the clinical manager each weekday, which allows the clinical manager to provide more support, guidance, and supervision to the nursing staff.
- It purchased a phone so that photos can be taken of wounds and the information included in the clinical records.
- It plans to provide education to staff on how to identify/observe resident breast abnormalities and how to palpate a breast to identify lumps and other medical issues.
- It has reminded staff of the need to follow up with resident families and NPs/GPs when admission forms have not been completed.
- It has reviewed its nutrition and hydration policy.
- Admission agreements are now discussed with the resident and family on admission, and the care facility manager is responsible for this.
- The acting operations manager has worked with the care facility manager and the clinical team to mentor and review nursing knowledge and understanding of safe practice and standards of documentation.
- Staff are now checking and reporting on the appearance of genitalia in the progress notes.

93. Further, Eileen Mary Age Care Limited's parent company has made the following changes in the context of its other operations since 13 November 2024:

- Established a group care and clinical governance structure, including a dedicated support office and a group clinical and quality manager, to provide clinical oversight; mentoring; leadership; regular care facility checks; and internal auditing and adverse event, complaint, and incident reviews to ensure compliance with accepted standards.
- The support office can now access the electronic clinical management systems remotely to provide real-time oversight to identify departures from best practice.
- Appointed a dedicated human resources manager to oversee recruitment and staff onboarding and orientation processes.
- Established an in-person clinical forum and ongoing monthly clinical meetings to discuss management of clinical care.
- Implemented regular care facility manager meetings.

- Appointed an experienced chief operating officer who is a registered nurse and has been tasked with driving safe, personalised, and individualised care.

94. Health NZ's Ageing Well and Service Improvement team completed a review of the complaints received by HDC. This review resulted in several meetings with Eileen Mary Age Care Limited and the new operator to discuss and implement service improvements. Weekly reporting and regular meetings were scheduled with Health NZ to monitor progress on actions related to improving staff support, clinical leadership, and education

95. The new operator said it continues to make improvements at the care facility, including improving staffing levels, staff retention, the appointment of a clinical nurse leader, the provision of extensive education and training to staff, and the ongoing development of strong collaborative relationships with the community. The new operator noted that the care facility's occupancy has increased over the last 10 months as community confidence in the care it provides has grown.

96. In addition, the new operator provided further correspondence from Health NZ, which stated that HealthCERT was reassured with the actions taken by the new operator. The new operator has said that they will continue to work with staff on the completion of all corrective actions and will communicate with HDC and HealthCERT regarding any concerns.

Recommendations and follow-up actions

97. I acknowledge the changes undertaken by Eileen Mary Age Care Limited. In addition, I make the following recommendations to the new operator of the care facility:

a) Undertake an audit of 10 deceased residents to determine whether an end-of-life care plan was established for the resident. A summary of the audit findings, including the corrective actions to be implemented, is to be provided to HDC within 18 months of the date of this report.

b) Undertake an audit of 10 residents who are known to experience chronic or acute pain, to determine whether the care provided to the residents complied with its Pain Management Policy. A summary of the audit findings, including the corrective actions to be implemented, is to be provided to HDC within 18 months of the date of this report.

c) Undertake an audit of the 15 most recent incidents relating to wounds in conjunction with the associated resident file to determine the degree of compliance with wound care against the new operator's wound management policy. A summary of the findings with corrective actions to be implemented is to be provided to HDC within 18 months of the date of this report.

d) Consider implementing weekly reviews of at-risk residents to ensure that appropriate clinical oversight of care is maintained, as suggested by RN Ferreira. Evidence of the weekly reviews being completed is to be provided to HDC within six months of the date of this report.

e) Consider strengthening the resident admission process to ensure that health backgrounds, precautionary care requirements, and goals of care are clearly reflected in the care record where possible, as suggested by RN Ferreira. An updated copy of the

Admission Policy and Procedures document is to be provided to HDC, along with a summary of the changes made, within three months of the date of this report.

f) Following completion of recommendation 96e), the new operator is to undertake an audit of the 10 most recently admitted residents to determine the compliance against its resident admission process. A summary of the findings with corrective actions to be implemented is to be provided to HDC within six months of the date of this report.

g) Establish regular meetings between the care facility management and GP/NP services to identify and address any concerns early, ensuring collaborative and timely resolution over any concerns. A summary of three meetings, including discussions held and any corrective actions to be implemented, is to be provided to HDC within six months of the date of this report.

98. An anonymised copy of this report (naming only Eileen Mary Age Care Limited, EMAC 1 Limited, and my clinical advisors) will be placed on the HDC website (www.hdc.org.nz) for educational purposes and forwarded to HealthCERT at the Ministry of Health | Manatū Hauora and Health New Zealand | Te Whatu Ora.

99. A copy of this report relating to the care provided to Ms B will be provided to the Coroner.

Nāku iti noa, nā

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was sought from RN Hilda Johnson-Bogaerts:

'**CONSUMER** : [Mrs A]

PROVIDER : Eileen Mary — Aged Care

FILE NUMBER : C22HDC00632

DATE : 14 May 2023

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Eileen Mary Age Care.

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

Specifically, I have been asked to review the provided clinical documentation and advise (i) if I consider the management of wound care provided to [Mrs A] following admission and up until maggots were identified in the wound to be in line with accepted nursing practice, and (ii) if I consider the facility wound management policy and the information provided in the response to be in line with current nursing best practice and to be sufficient to ensure sound education to nursing staff within the facility.

1. Documents reviewed

- Provider response dated 20 May 2022
- InterRAI assessment dated 10 February 2022
- Wound care plan 10295
- Clinical notes
- Adverse events document 20 February 2022
- Nursing progress notes, including family communication notes
- Education certificates and Toolbox notes

2. Complaint background as presented to me

[Mrs A] became a resident of Eileen Mary Care Home on 21 January 2022 to receive hospital-level care following a hospital admission to the Dannevirke community hospital where she had been since 23 December 2021 for exacerbation of congestive heart failure, bilateral leaking oedematous legs, and cognitive concerns.

Besides this, the interRAI assessments show that [Mrs A] had some degree of cognitive decline and memory problems. She needed extensive assistance with her activities of daily living and was able to mobilise with assistance. She was able to communicate her needs. Underlying medical history includes congestive heart failure, coronary heart disease, and dementia. While [in] hospital, she presented initially with several areas of concern on her legs and later developed a small area of concern on her sacrum, which was noted to have healed.

When she moved into Eileen Mary Care Home, these wounds were noted during the intake, and [Mrs A] continued to receive wound care. On 20 February 2022, maggots were found on her left lower leg wound, which the team immediately escalated. Betadine washes were initiated; however, the wounds continued to deteriorate.

I am extending my condolences to [Mrs A]'s family and friends with her passing in September 2022.

3. Review of clinical records

A wound care plan was developed at the time [Mrs A] moved into the care home, and a medical admission was completed a few days later. I note [Mrs A] received nutritional supplements as part of her care, and her dietary intake was reported to be good.

Reviewing the wound care plan, I note that her skin was described as very fragile, dry and itchy, prone to breakdown. The care plan includes that she needed pressure injury risk support and had a stage 1 (superficial) pressure injury on her foot, and her legs needed to be elevated up when sitting in her chair. The dressing was to be reviewed daily and changed as needed.

On 23 January 2022, a wound care plan was developed for a 'small open area' on her left lower leg, which was 'epithelising'. The care instruction read as to be cleaned with normal saline and bandaged with an absorbent pad and crêpe bandage toe to knee. This wound care plan was reviewed regularly and was noted to have a good prognosis for healing. The review on 9 February 2022 includes that the dressing needed to be monitored in addition to the daily dressing and the absorbent dressing needing now two layers and may need replacement when wet. The report of 17 February 2022 includes the need to review the bandage every shift and monitor for repositioning of the bandage by [Mrs A]. The progress notes include that [Mrs A] rewound the bandage at the ankle because she felt it was too tight.

20 February 2022: the progress notes include that maggots were found on the left lower leg while doing wound dressing. The facility manager was contacted for advice, who instructed to wash the wound with warm water and betadine. The family was notified. The medical review confirmed to continue with this regimen, and a swab was taken to ensure there was no infection.

Maggot infestation of a wound or wound myiasis occurs as a result of eggs depositing in pus-discharging wounds and is a condition in which the fly maggots feed off and develop in the tissue of a wound. Female flies may visit wounds to lay eggs. According to literature obtained on the following link (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6161638/), eggs at skin temperature hatch around 8–12 hours later and once emerged grow rapidly. Within 24 hours, they grow up to 7–8.5mm long.

The adverse event report includes that the wound fluid might have attracted flies from the sheep paddock next to the window during the warm weather and fly season. The incident report does not describe the size or quantity of maggots found, and no picture was included. The incident was escalated to make sure no infection was present as a

result. Better absorbent dressing was recommended to be used going forward and a review daily instead of every second day.

Because of the limited description in the adverse event report, and that no size of the maggots was included, it is not clear when the deposit of fly eggs in the wound/wound dressing might have happened.

The wound care plan required for the dressing to be checked every shift and replaced if wet but could otherwise be redressed every other day. This is in line with good practice for a wound that is 'epithelising', as described in the wound care plan. In the situation that the bandage was left wet, this would be seen by my peers as a deviation from accepted practice.

Reviewing the provider's Wound and Skin Care Management Policy, I have found the policy to be inadequate and lacking a holistic approach to wound care, lacking person-centric considerations (such as pain), and lacking considerations of the impact of wounds on the resident and their family. See the Skin and Wounds chapter of the Frailty Care Guides: (https://www.hqsc.govt.nz/assets/Our-work/Improved-service-delivery/Aged-residential-care/Publications-resources/Skin_wounds.pdf).

Reviewing the Wound care plan, I conclude that the wound care protocol was in line with wound care for epithelising wounds. However, the choice of type of absorbent bandages could potentially have been improved by using a higher absorbency. Further, I note a deviation from the organisation's policy in that no photos were taken and that no exact measurements were taken of the wound. I note from the minutes of the Toolbox talk of 20 May 2022 that "[…] to purchase a phone so that a photo can be taken and updated in HCSL". This seems to indicate that the nurses did not have the equipment to take photos and add these to the electronic notes.

I did not find in the provided documentation any reference of a referral of the wound to the DHB Wound Service for further advice as required by the policy when wounds do not improve for two weeks.

4. Clinical Advice

(i) In conclusion, I consider the management of wound care provided to [Mrs A] following admission and up until maggots were identified in the wound to have been somewhat deviating from accepted practice. I have come to this conclusion because documentation was not in line with the organisation's policy and accepted practice, dressing with a stronger absorbency could have been used, and I did not find evidence of a referral to the Wound Service while there was no significant improvement for two weeks.

(ii) I consider the facility wound management policy and the documentation of wound care to be a mild to moderate deviation from accepted practice and current nursing best practice and to be insufficient to ensure sound education to nursing staff within the facility.

(iii) In addition, I am concerned that the care home did not act earlier on the presence of flies and activate pest control measures. I am also concerned about the seemingly limited proposed remedial action as per the entry in the progress notes on 20 February 2022: "Her room needs a thorough clean and she has been encouraged to come out of her room more … Her neighbour […] is going to bring in some fly spray and also a fan to try and help remove flies from her room". What did the care home have in place in terms of pest control other than reliance on a visitor to bring in fly spray?

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Nurse Advisor (Aged Care)
Health and Disability Commissioner'

Appendix B: In-house clinical advice to Commissioner

The following in-house clinical advice was sought from RN Jane Ferreira: [re: Ms B]

Eileen Mary organisational questions	
Question 1: Whether the following policies available to staff at the time of the events were appropriate: a. Pressure injury and management b. Incident reporting c. Wound care d. Falls prevention and management e. Escalation of care f. Pain management	
List any sources of information reviewed other than the documents provided by HDC:	• Age-Related Residential Care Agreement • Ngā Paerewa Health and Disability Sector Standards • Health Quality and Safety Commission Frailty Care Guides (2023)
Advisor's opinion:	a. <u>Pressure injury and management</u> The Pressure (related Deep Tissue) Injury Prevention Policy (issued 27 June 2024) provides clear information about resident assessment, care and reporting responsibilities. The policy references contractual requirements and respected health resources. b. <u>Incident reporting</u> An incident report template has been supplied (issued 20 March 2023) but no policy guidance was sighted. c. <u>Wound care</u> The Wound and Skin Care Management Policy (issued 31 July 2024) belongs to the HCSL suite of policies and references respected health resources. Wound competency information is included with additional wound care guides. d. <u>Falls prevention and management</u> The Falls Prevention Programme (issued 20 March 2023) includes recognised care guidance, training and competency information e. <u>Escalation of care</u> The Advance Care Planning and Resuscitation Policy (issued 20 March 2023) refers to resident decision making, health pathways and goals of care.

	f. <u>Pain management</u> Pain Management policy (issued 20 March 2023) belongs to the HCSL suite of policies and references respected health resources. Supporting resource information on the above topics has also been supplied from the HQSC Frailty Care Guides (2023). The guides are designed to support existing organisational policies and clinical decision making. In summary, the reviewed policy information appears to be appropriate in the circumstances, although I am unable to comment on Adverse event management given the lack of policy content.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice standards are discussed within the reviewed policies.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	No departure identified in the content within the submitted policies.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No comment
Please outline any factors that may limit your assessment of the events.	No comment
Recommendations for improvement that may help to prevent a similar occurrence in future.	No comment

Eileen Mary organisational questions	
Question 2: Whether the training provided to Eileen Mary caregivers, including the competency framework is appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	• Age-Related Residential Care Agreement • Ngā Paerewa Health and Disability Sector Standards • Health Quality and Safety Commission Frailty Care Guides (2023)
Advisor's opinion:	Submitted evidence including a list of topics and educational material, knowledge quizzes, competency content from the HCSL suite of resources and training records reflect that the provider had an education process in place. Oversight and support has been provided by the funder and Health District Quality Service Improvement team with evidence of recommendations, planned and completed actions.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice is discussed in organisational policies, training material and competency information.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure	No departure identified.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No comment
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	No comment

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Ms [redacted]	
Factual summary of clinical care provided complaint:	
Brief summary of clinical events:	Background Ms [redacted] was admitted to the care home in May 2023 at hospital level of care. Her medical history included right MCA stroke with dense left-sided weakness (2022), hypertension, anxiety, GORD and intellectual disability. Ms [redacted] was non-mobile and required full assistance to reposition and meet all activities of daily living.

	On 25 April 2024 a lump was found in Ms [redacted] right breast during care delivery. The RN booked Ms [redacted] for a medical review at the next GP/NP round, scheduled for 2 May 2024. Between these dates a skin lesion and further breast lumps were identified. Ms [redacted] was assessed by the NP on 2 May and transferred to hospital the same day for further investigation. Ms [redacted] was diagnosed with advanced breast cancer and a decision was made for palliative care. Ms [redacted] was transferred back to the care home and sadly passed away on [redacted] May 2023. I extend my sincere condolences to Ms [redacted] family and friends at this time. Complaint Concern has been raised by the Office of the Coroner and Ms [redacted] GP regarding the timely recognition of breast changes and escalation of care. Provider Response The Provider has reviewed Ms [redacted] clinical file and discussed nursing actions with an event timeline. Clinical Notes While reviewed clinical records show daily care occurring, there appears to be an apparent delay in RN recognition of skin integrity changes and timely escalation of concern to the GP/NP for input in the circumstances.
Question 6: Whether Ms [redacted] breast wound was appropriately identified and escalated in a timely manner.	
List any sources of information reviewed other than the documents provided by HDC:	• Breast Cancer Foundation New Zealand https://www.breastnet.nz/topic/signs-of-breast-cancer • Mirfin-Veitch, B., Payne, D., Conder, J. & Channon, A (2016). Know who I am: Women with learning disability and their understanding and experiences of women's health screening in New Zealand. Donald Beasley Institute: Dunedin. https://www.donaldbeasley.org.nz/assets/publications/frozen-funds-charitable-trust-publications/Frozen-Funds-Report.Breast-and-Cervical-Screening.pdf

Advisor's opinion:	Expectations for the delivery of personal care are outlined in the organisation's Hygiene and Grooming policy and Personal Care and Hygiene Quiz (31 July 2024). The policy states (2A) 'Report any skin irritations, breaks, rashes, bruising or swelling to the senior person on duty'. The Personal Care and Grooming document discussed aspects of care delivery, noting the importance of 'patience and tailored care routines' File information showed that Ms [redacted] was assessed as being at high risk of compromised skin integrity related to her recent stroke event. Health resources recommend that checks of skin integrity for high-risk residents occur on all shifts to monitor for signs of concern (redness, swelling, localised heat, tissue inconsistency, broken areas and pain) and that RNs discuss concerns with the GP/NP. The provider has advised that skin assessments regularly occur by carers during delivery of resident care, and that any concerns are required to be escalated to the RN for further assessment. Progress notes 25 April 2024 state that a carer found a lump on Ms [redacted] right breast during personal care delivery and reported findings to the duty RN. The RN entry stated that a lump was noted under the right breast, and that Ms [redacted] had been added to the GP list for review. The entry provides no discussion of RN assessment, such as lump size, or signs of redness, swelling or pain on palpation, which would be considered accepted nursing practice. It appears from progress note records that no further assessment of the site occurred by RNs until 30 April 2024. Records state that an open lesion was found on Ms [redacted] right breast, which was cleaned and dressed. The entry stated that lumps were noted on both breasts, 'not painful, not movable mass'. It is unclear whether the RN sought guidance from the clinical manager or another senior nurse at the time. Records show that an incident report, STCP, wound photo and wound management plan were commenced, but it appears that GP/NP services were not informed about the identified breast changes with no evidence to show that clinical guidance was sought. Records 1 May 2024 report that wound dressings were in place. On 2 May 2024 Ms [redacted] was

	seen by the NP and transferred to hospital for further investigation. Health records show that Ms [redacted] was diagnosed with metastatic breast cancer (a likely new malignancy) and commenced on a palliative care pathway. From the evidence reviewed there seem to be delays in seeking GP/NP guidance in response to the changes in Ms [redacted] skin integrity. While RNs were proactive in scheduling a medical review, given the identification of further lumps and areas of skin breakdown it would be considered clinically indicated to escalate concerns for GP/NP support in the circumstances.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice is discussed in the submitted organisational policies and respected health resources.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	Mild to moderate departure regarding recognition of concern and timely escalation.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers in the circumstances
Please outline any factors that may limit your assessment of the events.	It is unclear from the reviewed health records if Ms [redacted] had regularly attended breast screening programmes or saw her primary care provider for routine breast examinations prior to admission to the care home. Health records refer to a maternal family history of breast cancer but this does not appear to be reflected in care home documentation to inform a precautionary plan of care.
Recommendations for improvement that may help to prevent a similar occurrence in future.	1.Consider strengthening the resident admission process to ensure that health backgrounds, precautionary care requirements and goals of care are clearly reflected in the care record where possible.

	2.Consider further education on nursing assessments, care planning and care escalation processes
Ms [redacted]	
Question 7: Whether the standard of wound/skin care provided to [redacted] in respect of the fungating breast wound was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	• Breast Cancer Foundation NZ https://www.breastnet.nz/topic/fungating-wounds
Advisor's opinion:	File information shows that Ms [redacted] and the care home team were well supported by the GP/NP and palliative care services. Care records show that following identification of breast cancer, clinical oversight and delivery of wound care was occurring in partnership with other health professionals, which appears appropriate in the circumstances.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As outlined in health resource information
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	No departure identified
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed similarly by my peers
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Ms	
Question 8: Any other comments you wish to make.	
List any sources of information reviewed other than the documents provided by HDC:	• Best Practice Advocacy Centre New Zealand (BPAC). Navigating the last days of life https://bpac.org.nz/2023/last-days-of-life/perspective.aspx • HQSC Frailty Care Guides: Care during the last days of life https://www.hqsc.govt.nz/resources/resource-library/care-during-the-last-days-of-life-pairuri-palliative-care-frailty-care-guides-2023/ • Te Ara Whakapiri: Principles and guidance for the last days of life https://www.tewhatuora.govt.nz/publications/te-ara-whakapiri-principles-and-guidance-for-the-last-days-of-life
Advisor's opinion:	Records show that prior to hospital admission Ms [redacted] had been experiencing signs of stress and distress with an increase in restlessness and vocalising, requiring additional doses of prescribed anti-anxiety medication. No reports of pain or discomfort were recorded in the care record. As outlined in health resources, all behaviour has meaning. It is unclear whether the displayed actions were considered as a sign of unmet needs, such as a response to pain. Ms [redacted] care plan stated that she experienced difficulty communicating and making her needs known. Entries in the care record stated that she was unable to verbalise pain or describe pain using a pain scale. While it appears that the care team knew her well, it seems that regular monitoring of pain was not implemented on her return from hospital. NP clinical records 9 May state that a management plan was discussed with nursing staff however there is no supporting information sighted. It appears that the long-term care plan was only updated on 15 May 2024 to reflect the use of PRN pain relief and anti-anxiety medications. There is no discussion of non-pharmacological strategies or other comfort measures to support her quality of life at this time. Given the change in health status as outlined on the

	discharge summary it would be considered accepted practice for nurses to review nursing assessments on return to the care home and implement a comprehensive palliative care plan. Progress notes describe changes to Ms [redacted] health and wellbeing indicating that her needs were changing. Records show that no changes were made to Ms [redacted] end-of-life plan care plan at this time. It appears that no care plan was commenced, such as Te Ara Whakapiri, for her last days of life which is considered accepted practice. As outlined in health resources, care during the last days of life requires frequent review of symptoms and adjustment of care needs in partnership with family/whānau and healthcare providers. From the evidence reviewed, there appear to be concerns with recognising and responding to signs of pain, care planning during the last days of life, and related documentation processes.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As outlined in organisational policies and health resource information
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	Mild to moderate deviations in the circumstances
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers in the circumstances.
Please outline any factors that may limit your assessment of the events.	Lack of pain assessment records
Recommendations for improvement that may help to prevent a similar occurrence in future.	Consider further education on pain management and end of life care planning.

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Appendix C: In-house clinical advice to Commissioner

The following in-house clinical advice was received from RN Jane Ferreira:

'**CONSUMER** : Mrs [D]
PROVIDER : Eileen Mary Care Home
FILE NUMBER : C23HDC00015
DATE : 12 December 2023

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Eileen Mary Care Home. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Documents reviewed.

- Letter of complaint received 9 January 2023.
- Provider response received 17 February 2023.
- Clinical records, including preadmission information, admission assessments, progress notes, wound care records, medication administration records, repositioning charts, GP health records.
- Organisational policies, including admission, adverse health and early warning, adverse event management, clinical documentation, communication, medication management, pain management, pressure injury prevention, quality assurance and risk management, wound management.
- Additional information received 16 May 2023, including medication records, wound policies, and HQSC Frailty Care Guides.

3. Complaint

[Mrs D]'s daughter has expressed concern about the care provided to her mother during a short-stay admission at the care home. Her concerns relate to informed consent, inadequate clinical care, and a lack of communication.

<u>Background</u>

[Mrs D] was admitted to the care home at hospital-level care on 21 October 2022. Prior to admission, she was cared for at home by whānau/family with community care support. Her medical history included advanced dementia/mate wareware, paroxysmal atrial fibrillation, hyperthyroidism, hypertension, bronchiectasis, increasing frailty, and functional decline. [Mrs D] presented to her GP on 23 September 2022 with community-acquired pressure injuries and was transferred to hospital for further assessment and care. Following treatment for wound and urinary infections, [Mrs D] was discharged to the care home for interim care pending formal assessment to enable her to return home. [Mrs D]'s health declined during her admission, and she was transferred to hospital in mid-November where she passed away. I extend my condolences to [Mrs D]'s family at this time.

4. Review of clinical records

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

a) Please review the submitted nursing records and comment if [Mrs D]'s admission process, including assessment, care planning and consent processes were in line with organisational policy.

Preadmission information shows that [Mrs D] had been hospitalised for a month with an unstageable left hip pressure injury and stage one sacral pressure injury. The nursing handover indicated that [Mrs D] was frail and required a high level of assistance to meet all activities of daily living. Hospital documentation discusses inpatient treatment for urinary and wound infections, recent delirium, and a need for ongoing wound care management. Discharge information refers to a pending needs assessment to determine the suitability of ongoing home care support or reassessment to long-term aged residential care.

As outlined in the Resident Admission policy, accepted practice would be to provide a comprehensive entry discussing the new resident's medical and nursing requirements, level of assistance with activities of daily living, any specific care or safety instructions and include confirmation of communication with nominated representatives. Reviewed admission progress notes completed by a registered nurse (RN) on 21 October 2022 provide no introduction or discussion of [Mrs D]'s care requirements for her short-stay admission. There is no reference made to the discharge summary, nursing handover, prescribed medications, her health and wellbeing status on admission, discussion of nursing assessments or an ongoing plan of care which would be considered accepted practice. The RN entry states that [Mrs D] had a dressing on her left hip, and that she reported pain while moving; however, there is no evidence of any pain or wound assessment completed, administration of pain relief or provision of related nursing interventions and care. There is no evidence of general practitioner (GP) involvement on admission or guidance sought regarding medical care requirements while residing at the care home. Given the distance between services, it is unclear what alternative medical supports were considered by the care home team prior to accepting [Mrs D] as a short-stay admission.

The admission policy outlines the admission process for permanent and short-term admissions, noting a preference to complete as much information as possible prior to the day of admission. The policy refers to responsibilities of the resident or their nominated representative to sign the admission agreement, and process to support the resident during the settling-in phase. The electronic care record shows no evidence of EPOA consultation or participation in care at this time, in line with organisational policies. Progress note entries reflect that communication occurred with [Mrs D]'s whānau/family on the day after admission to confirm EPOA status and activation. It is

unclear what process was discussed with [Mrs D]'s nominated representative regarding completion of the admission agreement and consent forms. [Mrs D]'s daughter has expressed concern that her mother was asked to sign the admission agreement despite having a diagnosis of cognitive impairment, and that clarification from her as EPOA was not sought. It is unclear why this responsibility was not determined by the care home leaders prior to admission to the care home and appropriate steps taken to ensure that professional and legal contractual obligations were met in an ethical manner.

The health platform shows that a range of nursing assessments were completed on the day of admission by an RN. The nutritional assessment stated that [Mrs D] had a history of weight loss, was at risk of malnutrition and regularly received a prescribed nutritional supplement. The Self-care, ADL and Skin assessment stated that [Mrs D] required full assistance with daily care needs and had fragile skin. The Braden pressure injury risk assessment scored (10), indicating high risk of pressure injury. The assessments and progress notes do not report the presence of existing chronic pressure injuries, requirement for pressure-relieving equipment or ongoing healthcare needs. While not reflected in the care record, it appears an incident report was completed in RiskMan, the provider's reporting system (#49435); however, it is unclear if a Section 31 external notification form advising Manatū Hauora | Ministry of Health that a resident had been admitted with a significant pressure injury was completed, which would be considered accepted practice and in line with adverse event policy requirements. Recommended practice would be to ensure that robust care planning was in place to support the principles of pressure injury management and address related goals for care (HQSC, 2019; HQSC 2023).

The Clinical Documentation and Report Writing policy states that assessments will be completed relevant to the resident's clinical presentation and that short-term care plans (STCPs) will be developed for acute clinical issues from the first day of admission.

There is no evidence that an STCP was commenced to manage [Mrs D]'s wound care requirements or overall care needs to minimise the risk of health decline during her short-stay admission. The policy states that nurses will ensure that comprehensive observations and related data are reported in progress notes, to inform care planning.

Progress notes indicate that [Mrs D]'s appetite was poor. Entries refer to minimal oral intake; however, there is no evidence of any monitoring of [Mrs D]'s nutritional needs commenced by RNs. Medication administration records indicate that she received the prescribed nutritional supplement, but there is limited evidence of RN oversight or use of critical thinking regarding the holistic principles of wound healing.

Preadmission information refers to a history of appetite concerns; however, there is no evidence of communication with [Mrs D]'s whānau/family regarding her nutritional needs or food and fluid preferences.

The pain assessment states that [Mrs D] was prescribed regular pain relief for her left hip. A pain score was not documented. The discharge summary and prescription indicate that [Mrs D] was prescribed paracetamol for administration three times daily. Progress note entries describe pain on repositioning and during personal care delivery,

with an RN entry 17 November stating that [Mrs D] might need a pain reliever before cares. Submitted medication administration records 9–19 November 2022 show that [Mrs D] only received one dose of as-required (PRN) paracetamol during this timeframe, on 18 November 2022. Progress notes indicate this had minimal effect, with signs of pain observed, and that the senior nurse had contacted the GP for stronger analgesia. It appears that [Mrs D]'s community GP was contacted twice regarding her medication management; however, there is minimal evidence of interaction with the GP or a request for medical assessment by the nursing team during [Mrs D]'s admission.

From the information reviewed, I have found the provision of nursing assessment, care planning and related documentation responsibilities to be of the lowest standard in the circumstances. Progress notes reviewed across [Mrs D]'s admission provide limited information of nursing assessment, intervention, and care. Entries lacked essential detail such as observation of weight, vital signs, pain or wound assessment, or related care evaluation. There is no evidence that short-term care plans were in use per organisation policy to guide the care team about [Mrs D]'s primary nursing requirements, no timely implementation of monitoring forms to record food and fluid intake, elimination patterns, pain or related care and safety requirements. There is limited evidence of engagement in activities to reduce the risk of social isolation or evidence of support provided to minimise the impacts of loneliness.

In conclusion, I consider the admission process and related nursing documentation lacked essential information to safely guide [Mrs D]'s care requirements. Discharge information was available; however, there appears to be inadequate planning on admission by the care home team, particularly regarding responsibilities to EPOA involvement and resident consent. While organisational policies were in place to guide practice standards, there appears to be blurring with nursing assessment, care planning, communication, and documentation responsibilities. There is limited evidence of proactive interaction with nominated representatives and allied health professionals and minimal evidence of senior nurse leadership and oversight of a short-stay resident's clinical care. As outlined in question (d), this appears to have contributed to a lack of critical thinking and clinical reasoning by the nursing team, which influenced professional responsibilities to recognise and respond to signs of acute health deterioration. I consider this to be a moderate to serious departure from accepted practice standards, and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

Additional comment

Progress notes entries report constipation concerns and indicate that a manual evacuation was performed by a nurse on 8 and 13 November 2022. Constipation in older people can be related to factors such as frailty, poor diet, dehydration, health history or medication involvement and can contribute to feelings such as nausea, abdominal pain and discomfort, urinary retention and/or urine infection (BPAC, 2019; HQSC, 2019; HQSC, 2023). Given [Mrs D] had recently experienced a urinary infection, monitoring of fluid intake, bowel and bladder records would be considered a nursing priority.

It is recommended that approaches to preventing and managing constipation are discussed in partnership with the resident, their support person, and the GP. This includes medication management or use of any alternative interventions. Digital disimpaction is not a recommended intervention when caring for older people, with a risk of causing rectal tears, bleeding or infection, pain, and distress. Accepted practice would be to review proactive nursing approaches to bowel management, such as diet, fluids, and use of regular toileting patterns, and seek GP guidance regarding medication management or specific care requirements prior to any nurse-led intervention. Nursing notes refer to an RN assessment, but there is no evidence of communication with the GP, a request for GP assessment, consideration of responsibilities to informed consent, or changes made to [Mrs D]'s plan of care, which would be considered accepted practice.

b) **Do you consider the communication between Eileen Mary Care Home, whānau/ family and the GP was appropriate in the circumstances?**

The Clinical Documentation and Report Writing policy provides clear guidance about professional interactions, communication, and documentation responsibilities. The policy states that all whānau/family involvement will be recorded in progress notes in the electronic record. The policy states that input will be sought from the resident's next of kin, whānau/family for the initial care plan. The communication policy states that 'the assigned family member, allocated as having responsibility for providing input into care planning, must be contacted prior to medical reviews to ensure they have the ability/opportunity to provide input'. The Clinical Documentation and Report Writing policy states that the resident's EPOA will be informed of all injuries, events, or health concerns.

Progress note entries reflect that communication with [Mrs D]'s daughter as nominated representative occurred three times during her admission. The Clinical Documentation and Report Writing policy states that when communicating with the GP/NP or hospital regarding an urgent clinical presentation to use the Frailty-Modified ISBAR tool, which is in line with recognised resources to guide nursing practice (HQSC, 2019; HQSC, 2023). Reviewed progress notes state that the GP was contacted twice during [Mrs D]'s admission; however, there is no evidence of this communication or discussion of clinical guidance received reported in the electronic care record. Shift handover records were supplied for 17–19 November, which outline identified care priorities at the time. Documentation indicates that the care team had identified a change in [Mrs D]'s presentation from 16 November, but there is no evidence of escalation to the GP or that her daughter, as nominated representative, was informed.

As outlined in organisational policies, effective, open communication is vital to ensuring the delivery of quality, person-centred resident care in partnership with the resident, their EPOA, whānau/family and the health care team. Nursing documentation, including assessments, care plans, monitoring forms and progress notes are used to communicate resident care requirements, care delivery, identify and report concerns, including significant changes or events that occurred across the shift.

From the information reviewed to respond to this question, I consider that communication and reporting processes were below the accepted standard in the circumstances. There is no evidence of open communication with [Mrs D]'s EPOA regarding her health and wellbeing and signs of decline, or timely escalation of clinical concerns to the GP and involvement of acute care services, as outlined in the guidance for short-stay admissions. I consider there to be moderate to serious deviations from organisational policy and accepted practice standards, and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

c) Do you consider the management of [Mrs D]'s skin integrity was in line with organisational policy?

The Wound Management policy provides clear guidance regarding expectations for the provision of wound care at the care home. The nursing handover form states that [Mrs D] was discharged from hospital with frailty and chronic pressure injuries. The document outlines her care requirements, noting that a pressure-relieving mattress was required and that wound dressing changes were due 22 October 2022.

Admission progress notes report that a left hip dressing was in situ but there is no discussion of a sacral site or scheduled wound care plan. The care record reflects that skin integrity and pressure injury risk assessments were completed on the day of admission in line with the admission policy, but it is unclear what pressure-relieving interventions were commenced at this time or what equipment was in use.

A progress note entry on 4 November 2022 reports that [Mrs D] had red heels. An RN recommended placing a pillow under her heels to offload pressure but there is no evidence of skin assessment, review of mobility or equipment use, or that a precautionary management plan was commenced. On 6 November, a carer reported signs of redness on the sacral area. It is unclear whether the site had been reviewed by an RN in the two weeks post-admission as there is no discussion in progress notes or evidence of a wound management plan in line with organisational policy. Progress notes state that a dressing was applied, and to maintain turns. There is no evidence of guidance provided about repositioning requirements or associated risk minimisation strategies. Records show the repositioning record was only commenced 12 November 2022. A progress note entry the same day states that a Roho cushion was put on [Mrs D]'s bed. It is unclear whether [Mrs D] had an air mattress in place as related information regarding mattress settings on the form is incomplete.

Progress notes state that the sacral dressing was changed on 8, 14 and 16 November; however, the submitted wound management documentation shows that a wound care plan was only commenced for the sacral site on 12 November 2022 (18068). There appears to be blurring with injury identification as the discharge summary shows that [Mrs D] had presented to hospital with a community-acquired pressure injury and had been discharged from hospital to the care home with an existing injury for ongoing management. The report states that a stage one pressure injury was identified on 8 November 2022, measuring 7x5cm with a plan for weekly dressings. Electronic records

show the site was reviewed by an RN on 16 November with a planned review date of 19 November 2022.

A wound care plan for the unstageable left hip injury was also commenced on 12 November 2022 (18067). Records show it was identified on admission 22 October, measured 7x4cm, with a goal to prevent deterioration and lift the necrotic layer. The first progress note entry regarding the unstageable pressure injury was on 16 November 2022 where the RN reported a change of dressing and wound debridement. Entries provide no discussion of wound presentation, assessment, or evaluation. The supporting wound assessment on 16 November is incomplete, with the following reported:

— Wound inspection: Sloughy
— Skin condition around wound: N/A
— Exudate: N/A
— Assessment/actions: NA
— Comments: debrided and cleaned with NS, 50/50 solosite, iodosorb
— Pain score: 3

I consider the lack of essential information and lack of supporting rationale for the comments to be below accepted practice standards. Signs of change in a wound bed and the surrounding tissue, such as redness, pain, swelling, a presence of exudate and odour are key identifiers of concern and should prompt the RN to complete a robust, holistic nursing assessment, including observation of vital signs (HQSC, 2019; HQSC, 2023). There is no supporting photograph of the unstageable pressure injury post-debridement, discussion of the procedure and related assessment evidenced in the care record. It is unclear which pain assessment tool was used to clarify verbal and non-verbal signs of pain. As discussed in question (a) it appears that indications for prescribed pain relief were not considered or provided to [Mrs D], which is not in line with pain management principles. It is also unclear whether the duty RN was aware of carer comments in progress notes that [Mrs D] had appeared in pain and not her usual self on 16 November, which may have prompted earlier escalation for senior nurse support.

From the evidence reviewed to respond to this question, it appears that the assessment and management of [Mrs D]'s skin integrity was inadequate in the circumstances. There appears to be limited senior nurse oversight of complex wound care, with delays in completing the wound assessments, specific wound care plans, timely care delivery and evaluation, which does not align to policy guidance and accepted practice standards. There is no evidence of collaboration with the wound nurse specialist regarding [Mrs D]'s wound status, which would have been considered appropriate in the circumstances.

- Departure from accepted practice: Moderate to serious.

d) Please comment on the recognition of change and decline and related care escalation.

As outlined in organisational policies, the care team are responsible for providing timely delivery of person-centred care, observing, and reporting on resident status.

Progress notes reflect that changes were reported to the RN; however, there appears to be a lack of nursing assessment or awareness of [Mrs D]'s health decline by the RN team. Entries in the care record indicate that [Mrs D] was showing signs of unwellness on 16 November. On 17 November, entries describe [Mrs D] as weak, with signs of pain during cares. An RN entry requests carers to encourage oral fluids and comments that a pain reliever may be useful before cares, but there is no evidence of escalation or action until the following day. Entries on 18 November describe [Mrs D] as frail, noting that Panadol had little effect; however, there is limited evidence of a holistic review completed by the clinical leader prior to reportedly informing the GP, or alerting [Mrs D]'s EPOA of her health decline. This shows a lack of critical thinking, clinical reasoning, and decision-making by the nursing team. Progress note entries on 19 November evidence escalation by the RN to the clinical leader for support and guidance, which is considered recommended practice. A decision was made to communicate with [Mrs D]'s EPOA and transfer [Mrs D] to hospital for acute assessment, which is reflected in the care record. File information has referred to delays with care home access, and concerns with resident care, communication, and transfer processes, which the provider has acknowledged in their response.

Short-stay admissions can present high risk, and I am concerned about the standard of care provided to [Mrs D] during her stay at the care home. The clinical documentation and report writing, adverse health and early warning, adverse event policies, including the submitted health resources, indicate that systems and processes were in place and that professional guidance was available to the nursing team to guide their practice. The submitted documentation provides limited evidence of senior nurse oversight of a frail older person with a complex wound. There is limited evidence of engagement with external health professionals and other stakeholders, a lack of care awareness or recognition of decline, and poor communication with whānau/family as her primary carers.

From the evidence reviewed to respond to this question, I consider the care provided to [Mrs D] to be below the accepted standard of practice in the circumstances.

- Departure from accepted practice: Moderate to serious.

e) Please provide comment on the corrective actions completed in response to this complaint.

The provider has acknowledged that the care provided to [Mrs D] was below their standard of accepted practice and apologised. They have discussed identified areas for improvement and submitted evidence of education provided on open disclosure, communication and documentation standards, resident admissions, nursing assessment, and management of pain, pressure injuries and wounds, which appears appropriate in the circumstances. I recommend the provider considers their

preadmission responsibilities to respite/short-stay resident admissions, including team awareness of EPOA processes and informed consent to reduce the risk of recurrence. I also recommend the provider review their process for ensuring the care home team can access clinical and operational policies and are aware of their professional responsibilities to apply this information to their practice.

5. Clinical advice

Based on this review, I recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. To support this approach, I recommend that the care home team complete the HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

References

Best Practice Advocacy Centre (BPAC). (2019). Managing Constipation in Older People. https://bpac.org.nz/2019/constipation.aspx

Health and Disability Commissioner. (2022). Online Learning. https://www.hdc.org.nz/education/online-learning/

Health Quality & Safety Commission. (2019). Frailty Care Guides. http://www.hqsc.govt.nz/

Health Quality & Safety Commission. (2023). Frailty Care Guides. http://www.hqsc.govt.nz/'

Appendix D: In-house clinical advice to Commissioner [re: Mrs E]

Eileen Mary organisational questions	
Question 1: Whether the following policies available to staff at the time of the events were appropriate: a. Pressure injury and management b. Incident reporting c. Wound care d. Falls prevention and management e. Escalation of care f. Pain management	
List any sources of information reviewed other than the documents provided by HDC:	• Age-Related Residential Care Agreement • Ngā Paerewa Health and Disability Sector Standards • Health Quality and Safety Commission Frailty Care Guides (2023)
Advisor's opinion:	a. <u>Pressure injury and management</u> The Pressure (related Deep Tissue) Injury Prevention Policy (issued 27 June 2024) provides clear information about resident assessment, care and reporting responsibilities. The policy references contractual requirements and respected health resources. b. <u>Incident reporting</u> An incident report template has been supplied (issued 20 March 2023) but no policy guidance was sighted. c. <u>Wound care</u> The Wound and Skin Care Management Policy (issued 31 July 2024) belongs to the HCSL suite of policies and references respected health resources. Wound competency information is included with additional wound care guides. d. <u>Falls prevention and management</u> The Falls Prevention Programme (issued 20 March 2023) includes recognised care guidance, training and competency information e. <u>Escalation of care</u> The Advance Care Planning and Resuscitation Policy (issued 20 March 2023) refers to resident decision making, health pathways and goals of care.

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	f. <u>Pain management</u> Pain Management policy (issued 20 March 2023) belongs to the HCSL suite of policies and references respected health resources. Supporting resource information on the above topics has also been supplied from the HQSC Frailty Care Guides (2023). The guides are designed to support existing organisational policies and clinical decision making. In summary, the reviewed policy information appears to be appropriate in the circumstances, although I am unable to comment on Adverse event management given the lack of policy content.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice standards are discussed within the reviewed policies.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	No departure identified in the content within the submitted policies.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No comment
Please outline any factors that may limit your assessment of the events.	No comment
Recommendations for improvement that may help to prevent a similar occurrence in future.	No comment

Eileen Mary organisational questions	
Question 2: Whether the training provided to Eileen Mary caregivers, including the competency framework is appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	• Age-Related Residential Care Agreement • Ngā Paerewa Health and Disability Sector Standards • Health Quality and Safety Commission Frailty Care Guides (2023)
Advisor's opinion:	Submitted evidence including a list of topics and educational material, knowledge quizzes, competency content from the HCSL suite of resources and training records reflect that the provider had an education process in place. Oversight and support has been provided by the funder and Health District Quality Service Improvement team with evidence of recommendations, planned and completed actions.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice is discussed in organisational policies, training material and competency information.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure	No departure identified.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	No comment
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	No comment

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Mrs [redacted]	
Factual summary of clinical care provided complaint:	
Brief summary of clinical events:	<u>Background</u> Mrs [redacted] was admitted to the care home on 5 August 2022 and was living at hospital level care during the timeframe in question. Her medical history included dementia/mate ware-ware, Parkinson's disease, moderate aortic stenosis, type 2 diabetes, gout, dyslipidaemia, hypertension, osteoarthritis and falls. Mrs [redacted] sustained a right hip fracture in a fall event on 22 November 2023, requiring surgical repair, and returned to the care home on 29 November 2023. Records describe signs of increased frailty noting that Mrs [redacted] required increased carer assistance to reposition and meet all activities of daily living. Mrs [redacted] developed a sacral pressure injury in December 2023 which required involvement by a range of health professionals. Records show that Mrs [redacted] remained frail and sadly passed away on [redacted] August 2024 related to her health background. I extend my condolences to Mrs [redacted] family and friends at this time. <u>Complaint</u> Concerns have been expressed about the identification and management of Mrs [redacted] sacral pressure injury, including effective communication with clinicians. <u>Provider Response</u> The Provider has reviewed Mrs [redacted] clinical file and discussed care actions with an event timeline. <u>Clinical Records</u> Reviewed clinical records including progress notes, care plan evaluations and wound care records show care occurring. While records discuss timely referral for specialist involvement in wound care, there appears to be a delay in escalating wound care concerns to the GP/NP for input in the circumstances.

Question 3: Whether the pressure injury care provided to Mrs [redacted] was appropriate. As part of this, please comment on the appropriateness of any preventative measures implemented, care planning, as well as identification and management of the unstageable pressure injury.	
List any sources of information reviewed other than the documents provided by HDC:	• HQSC Frailty Care Guides: Wound Care https://www.hqsc.govt.nz/resources/resource-library/wound-assessment-te-aromatawai-taotu-frailty-care-guides-2023/
Advisor's opinion:	Clinical records show that Mrs [redacted] had vulnerable skin integrity with history of a previous sacral pressure injury (Aug 2023) and considered resolved (Sept 2023). Care plan information showed that a pressure-relieving mattress remained in use as a precautionary risk reduction measure. Mrs [redacted] was considered to be at high risk of falls and bed rail restraint was utilised as a falls prevention strategy. Care plan evaluation records (30 June, 30 Aug 2023) report that Mrs [redacted] was also restrained while seated. Reviewed progress note entries and repositioning forms report regular position changes as part of restraint management responsibilities and pressure-relieving actions. InterRAI assessments and a long-term care plan provide evidence of regular care review across Mrs [redacted] admission. Evaluation comments discuss signs of increasing frailty and health decline related to advancing dementia and Parkinson's disease processes. It appears that documentation of precautionary care interventions were appropriate in the circumstances. Mrs [redacted] returned to the care home from hospital on 28 November 2023 following hip surgery for a fall with fracture event. Progress notes reflect that a verbal handover had been provided to a care home registered nurse (RN) prior to her return. Supporting information stated that Mrs [redacted]'s skin integrity was intact at discharge, noting that a pressure relieving mattress was required to reduce the risk of pressure injury. RN progress note entries discuss Mrs [redacted] surgical site and ongoing care needs. It does not appear from the submitted records that a skin assessment was completed on her return from hospital which would be considered accepted

	practice. A short-term care plan (STCP) was commenced for post-fracture care which included a repositioning chart, and relevant care interventions per template prompts. Given Mrs [redacted] reported frailty it would be recommended to implement daily skin checks of bony prominences with regular clinical review by RNs to ensure timely escalation of concern to GP/NP services. Progress notes 4 December 2023 report redness and concern with Mrs [redacted]s sacral skin integrity. An RN assessed the site with progress notes reporting nursing actions, which included communication with family/whānau. It appears that a wound management plan was not implemented by the RN nor STCP updated to reflect changes in risk and precautionary care needs at this time. Progress notes discuss continence-related skin concerns, the application of barrier creams and a dressing to support skin integrity. Entries 6 December discuss wound review and report that Mrs [redacted] remained in bed to reduce pressure on her sacral area. This intervention was supported by the Facility Manager (FM)/RN (8 December), noting that Mrs [redacted] would now remain in bed on alternate days. It is unclear how this instruction was communicated to ensure continuity of care across shifts, with no apparent update to the care plan. Progress notes 7 December 2023 report a decline in Mrs [redacted]s sacral site. An RN assessed the wound as a stage 2 pressure injury, and completed an incident report, STCP and wound management plan which is in line with policy guidelines, although it appears that the GP/NP were not informed. Corrective actions discuss recognised interventions; pressure relieving equipment use (air mattress, roho cushion), regular repositioning, close observation of wound care, and improved nutrition to support wound healing. Wound records, photos and progress notes continue to report signs of wound decline. An event report 19 December 2023 documented concerns with a non-healing wound and commencement of antibiotic therapy, which suggests that communication with

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	GP/NP services had occurred. Progress notes state that Mrs [redacted] family/whānau were aware of the wound decline and referral to specialist wound services, but the care record provides no comment about GP/NP involvement in resident review and referral processes which would be considered accepted practise. Presence of pain appears to have been informally assessed across shifts. Regular entries state that Mrs [redacted] presented with no signs of pain or discomfort but also noted that she experienced difficulty understanding a pain scale. It appears from reviewed progress notes that the care team knew Mrs [redacted] well and were responsive to her needs, however a non-verbal pain assessment tool was not introduced until February 2024. Given Mrs [redacted] recent hip surgery, cognitive impairment, frailty and limited ability to reposition it would be considered accepted practice for regular pain monitoring to be occurring as part of evidence-based nursing practice to inform safe clinical decisions. Email communication from tissue viability services acknowledged referral for the unstageable sacral pressure injury, noting that Mrs [redacted] had been added to a virtual consultation list. A detailed wound care plan was provided with guidance to change the dressing every three days. Progress notes and care records state the wound care plan was updated using viability wound service instruction. The provider response stated that the NP was first notified about Mrs [redacted] pressure injury when they visited on 11 January 2024. Progress notes 11 January state that Mrs [redacted] was clinically reviewed by the NP with Medi-map alerts reflecting medication changes. Further support was received from wound services 12 January 2024 with prompts about ongoing nursing assessment and care. Records show that responsibilities to external reporting were met with a pressure injury notification sent 12 January by the FM/RN to HealthCERT, in line with policy guidance, and that consultation occurred with Dietitian services about Mrs [redacted] nutritional needs to support wound healing.

	Additional evidence is provided to show that education about pressure injury prevention and management was provided to the direct care team on 29 January 2024. Documentation received from wound care services stated that regular support had been provided to the nursing team regarding Mrs [redacted] wound care with comments made that she appeared well cared for with wound improvement noted and appropriate strategies in place. From the evidence reviewed it appears that delivery of wound care was occurring with appropriate nursing processes in place. As outlined in discussion points there appear to be deviations noted in clinical oversight, timely communication with GP/NP services, pain management processes, and documentation standards which would be viewed similarly by my peers.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice is discussed in the submitted organisational policies and respected health resources
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	Mild to moderate departures identified
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Consider implementing weekly reviews of at-risk residents to ensure appropriate clinical oversight of care is maintained

Mrs [redacted]	
Question 4: Whether the unstageable pressure injury was appropriately escalated to the primary care team.	
List any sources of information reviewed other than the documents provided by HDC:	• HQSC Frailty Care Guides: Wound Care https://www.hqsc.govt.nz/resources/resource-library/wound-assessment-te-aromatawai-taotu-frailty-care-guides-2023/
Advisor's opinion:	The HQSC Frailty Care Guides provide decision support for pressure injury care. The flow chart shows that clinical advice should be sought from the GP/NP and wound specialist (WS) for all stage 3, stage 4, unstageable and suspected deep tissue injuries. Wound care guidance recommends that signs of risk or concern with wound decline are reported to the GP/NP for further assessment and care. Organisational policies clearly discuss expected approaches to pressure injury management and resident care. The submitted Braden pressure injury risk assessment tool states that *pressure injury risk will be reviewed on resident return from hospital stays, and that any increase in risk level must be notified to the GP/NP*. Records show that a Braden assessment was completed (12 Dec 2023) with a High-Risk outcome score (12). While incident records (7 Dec 2023) show the FM/RN was notified of the stage 2 pressure injury, it appears that the medical team (GP/NP) were not informed at this time. Corresponding progress notes provide no indication that open communication occurred between RNs and the medical practice regarding Mrs [redacted] skin integrity, particularly given her recent surgery and identified frailty, which would be considered accepted practice. Wound care records show that Mrs [redacted] pressure injury rapidly declined from stage 1 to unstageable status, with signs of infection identified in Dec 2023. While records show that medications were charted by the GP/NP, it appears that concerns with wound status were not escalated, and records indicate that the site was first seen by the team on 11 Jan 2024.

	From the evidence reviewed it appears that the primary care team were not specifically informed by RNs of Mrs [redacted] sacral pressure injury or the identified decline in wound status per policy guidelines.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice is discussed in the submitted organisational policies and respected health resources
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	I consider there to be moderate departures in communication and documentation processes in the circumstances
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed similarly by my peers
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Consider further education about care partnership, effective communication and service delivery responsibilities
Mrs [redacted]	
Question 5: Whether the communication practices between Eileen Mary care team and primary care team was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	While nursing records reflect that care was occurring, including consultation with external health specialists, there appears to be limited documented evidence of regular communication occurring between the nursing and medical teams regarding Mrs [redacted] clinical care, particularly between December 2023 and February 2024. The provider's letter states that the medical centre was

	informed of Mrs [redacted] sacral pressure injury in December 2023 based on wound decline and a request for antibiotic therapy, however the timeline has stated that the NP was only notified of the pressure injury during a care home visit on 11 January 2024. Regular communication between services regarding resident care is considered accepted practice to ensure appropriate delivery of a clinical plan of care. The provider has discussed the use of the ISBAR communication tool which is a recommended process to ensure that essential clinical information is shared between healthcare teams with a documented plan. From the evidence reviewed there appear to be gaps in recordkeeping as part of professional responsibilities
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Accepted practice is discussed in the submitted organisational policies and respected health resources
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	Moderate departures identified in documentation of care interactions between the care home and primary care team.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed similarly by my peers
Please outline any factors that may limit your assessment of the events.	Lack of communication records
Recommendations for improvement that may help to prevent a similar occurrence in future.	Consider further education about communication pathways and professional responsibilities

Mrs	
Question 5: Any other comments you wish to make.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	No further comments to add
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Appendix E: In-house clinical advice to Commissioner

The following in-house clinical advice was received from RN Jane Ferreira: [re: Mrs F]

Mrs [redacted]	
Factual summary of clinical care provided complaint:	
Brief summary of clinical events:	Background
	Mrs [redacted] was admitted to the care home in 2017 and resided at hospital level care. Health records show that Mrs [redacted] was living with multiple long-term health conditions including atrial fibrillation, hypertension, ischaemic heart disease, dyslipidaemia, stroke, postural tremor, congestive cardiac failure, gout, rectal prolapse and Paget's disease of the vulva. She was independently mobile with a walker and required assistance with activities of daily living. Reviewed health records show that Mrs [redacted] experienced long-term pain and discomfort with elimination difficulties related to her health history which impacted her quality of life. She was regularly seen by medical teams and known to specialist gynaecology services. The provider has advised that Mrs [redacted] clinical file was reviewed during a HealthCERT surveillance audit which identified a lack of information in nursing records about her skin integrity and related care.
	Complaint
	Concerns have been raised about the nursing care provided to Mrs [redacted] by the care home, specifically clinical oversight of health needs, personal care, wound care and pain management.
	Provider response
	The provider has stated that Mrs [redacted] had been living with a long-term skin condition and received treatment for persistent, ongoing issues with pain and rashes related to her diagnosis of Paget's. The response stated that Mrs [redacted] was prescribed regular and as-required (PRN) pain relief, and that they relied on her to self-report pain to enable them to administer medications. The provider has advised that resident care is directed by a care plan and delivered by trained caregivers (CG) who are supported by registered nurses (RN). The response states that CGs will report any concerns with a resident's skin integrity to the RN for follow up or action. No specific comment is provided about concerns with personal care.

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	Clinical notes Medical records (2020-2024) show that Mrs [redacted] was well known to the practice and seen regularly by the primary care team (GP/NP). Reviewed progress notes provide discussion of daily care occurring with routine statements by RNs and CGs. Evidence-based RN actions, such as findings from skin, pain, vital sign assessments, review of monitoring forms or elimination records, were not well documented in progress notes. There is no evidence of clinical oversight by a senior nurse, nor use of specific care plans to guide Mrs [redacted]'s care requirements, with no evidence of care evaluation. Medical records show that RNs contacted the medical practice with clinical concerns using the ISBAR communication tool, however RN actions in response to clinical orders are not consistently documented in nursing records which is concerning. Progress notes report administration of PRN pain relief via MediMap, but pain assessment scores or medication effectiveness was not reported. I note that MediMap administration records record this information but it is unclear how often these records were reviewed by RNs. There is minimal discussion of non-pharmacological strategies to support pain or discomfort. Progress note entries show that communication occurred between the care home and Mrs [redacted]'s family, such as fall event notifications, with documentation of care concerns raised by family, however there is no evidence supplied of incident and complaint management processes, such as incident forms and communication records.
Question 9: Whether the wound/skin care provided in respect of the vaginal rash was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	• Best Practice Advocacy Centre New Zealand. (2014). Vulvovaginal health in post-menopausal women bpac.org.nz • https://bpac.org.nz/bpj/2014/september/vulvovaginal.aspx#:~:text=Age%2Drelated%20changes%20in%20women,tract%20infection%20and%20sexual%20dysfunction.

- HQSC. (2023.) Frailty Care Guides: Wound Management https://www.hqsc.govt.nz/resources/resource-library/wound-care-te-maimoatanga-o-nga-taotu-frailty-care-guides-2023/

Advisor's opinion:

Records show that Mrs [redacted] was living with a chronic health concern which caused her significant distress. She experienced pain on elimination with continence difficulties and was prone to urinary infections. Reviewed health resources discuss the importance of good personal hygiene, supportive interventions to reduce discomfort, recognition of change in skin integrity and symptom management.

Medical notes show regular GP/NP involvement in Mrs [redacted] care with review of prescribed medications and care strategies for Mrs [redacted] rash, including specialist involvement in her care. GP/NP clinical orders are clearly stated, such as (17 May 2024) ... '*RN to check the area daily for skin breakdown and advise if change from redness to worsening skin'*. Unfortunately, there are no corresponding nursing progress notes sighted for this visit in the supplied records. There is no evidence to show that an RN commenced a short-term care plan with no skin/wound care records implemented to evidence that daily skin integrity assessments were provided by an RN, per NP orders. The provider has shared a long-term care plan which reflects skin care management and evaluation (18/8/24, 20/10/24, 10/12/24) however supporting assessment and care information is limited to inform further comment.

Reviewed progress notes report that Mrs [redacted] regularly experienced episodes of genital pain and bleeding. Medical records show that a clinical plan of care was in place, however related nursing information reflects minimal oversight, interaction and evaluation by RNs. It would be considered accepted practice to ensure that skin and wound care requirements were clearly documented in a care plan to ensure appropriate delivery of resident care, in line with clinical instructions. While CG entries show that care escalation processes were occurring, there is

	very limited evidence of RN oversight of Mrs [redacted] skin integrity documented in reviewed records.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material	The ARRC agreement (D5.4) states that providers are required to have policies on a range of topics including pain management, skin management and wound care. Resident care needs are required to be documented in a care plan (16.3) and available to all direct care staff. Support and care is required to be delivered to the resident in a timely and competent manner. The provider's policies belong to a comprehensive suite of guiding documents that reference contractual responsibilities and expectations for resident care. Supporting health resources discuss the importance of assessment and care documentation as part of evidence-based practice to inform clinical judgement and decision making.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	From the evidence reviewed there appear to be mild departures in documentation standards in the circumstances.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers
Please outline any factors that may limit your assessment of the events.	Lack of clinical documentation to inform further comment
Recommendations for improvement that may help to prevent a similar occurrence in future.	Consider further education on nursing assessments, care planning and reporting responsibilities
Mrs [redacted]	
Question 10: Whether the management of pain in respect of the vaginal rash was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	Best Practice Advocacy Centre New Zealand. (2014). Vulvovaginal health in post-menopausal women bpac.org.nz

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	https://bpac.org.nz/bpj/2014/september/vulvovaginal.aspx#:~:text=Age%2Drelated%20changes%20in%20women,tract%20infection%20and%20sexual%20dysfunction. HQSC (2023.) Frailty Care Guides: Pain https://www.hqsc.govt.nz/resources/resource-library/pain-mamae-frailty-care-guides-2023/
Advisor's opinion:	The organisation's Pain Management policy (issued 20 March 2023) states that each resident who suffers any form or degree of pain shall have a written and implemented plan for pain management within their care plan. Approaches to holistic pain assessment and management are discussed, and state that the RN, clinical lead nurse or facility manager are responsible for ensuring that regular pain level monitoring is carried out in conjunction with monitoring effectiveness of interventions. The Long-term care plan (20 Aug 2024) stated that Mrs [redacted] goal was to be as pain free as possible day and night. Evaluation comments state that Mrs [redacted] pain was controlled with regular analgesia. Pain assessment records (July/Aug 2024) show that regular monitoring was in place using an organisational pain assessment tool. Medication administration records show that pain scores were used with effectiveness reported in the MediMap records. There are no supporting entries within progress notes which presents an improvement opportunity. The Pain Management policy (4) states that some pain relief medications (e.g. Codeine) can cause constipation and to ensure monitoring of bowels and treatment of specific symptoms as identified. Progress notes report that Mrs [redacted] was given PRN doses of Codeine for reports of pain. There is no evidence of care review completed by RNs or care home leaders about pain management, frequency of medication use, efficacy or side effects recorded in progress notes per policy guidelines. InterRAI assessment findings 26 May 2024 stated that Mrs [redacted] experienced pain in her hands, shoulders and back, managed with administration of regular

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	Paracetamol and PRN Codeine. Medication records and progress notes report multiple entries of Codeine given for vaginal pain although there is minimal evidence of RN assessment, oversight of PRN medication use or care review. While progress notes acknowledge GP/NP visits, there is limited discussion of clinical concerns, assessment findings, changes to the clinical plan of care or specific nursing interventions. Records show that only one short-term care plan was implemented during the timeframe. File information shows that the long-term care plan (Skin Care section) was updated to reflect genital pain, possibly in response to audit findings (26 Aug 24).
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Organisational policies and supporting health resources discuss expectations for the assessment and management of pain.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	Mild to moderate departures concerning pain management
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Consider further education and training on the assessment and management of resident pain.

Mrs [redacted]	
Question 11: Whether the documentation practices were appropriate. As part of this, please comment on Eileen Mary's statement that Paget's disease is a long-term skin condition which did not require a specific wound care plan to be developed.	
List any sources of information reviewed other than the documents provided by HDC:	• HQSC Frailty Care Guides 2023. Wound Assessment https://www.hqsc.govt.nz/resources/resource-library/wound-assessment-te-aromatawai-taotu-frailty-care-guides-2023/
Advisor's opinion:	The provider has stated that a specific wound care plan was not required for Mrs [redacted] rash in the circumstances and that skin integrity was monitored during the general handover process. It would be considered accepted practice for RNs to ensure that all care interactions are reported in the resident's clinical file with relevant concerns handed over to the incoming shift as part of professional responsibilities. Documented evidence of RN oversight and involvement in Mrs [redacted] care appears limited. The provider has stated that since 2023 Mrs [redacted] had been reviewed at least 26 times by a GP/NP. This would suggest that she was receiving prescribed treatment for a long-term health condition that required regular RN oversight, and reflection in the long-term care plan. I note that the clinical record (InterRAI and Care Plan) have since been updated accordingly to reflect the identified needs.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	It would be considered accepted practice to ensure that skin integrity was discussed in a long-term care plan with a focus on preventing exacerbations, recognition of concern, symptom management, and clinical care to support Mrs [redacted] quality of life. As outlined in resource documents, areas for consideration could include skin care, continence management, infection risk, hydration, nutrition, and elimination needs, pain management, specific care guidance about prescribed treatments, GP/NP involvement and specialist reviews to inform a personalised plan of care.
Was there a departure from the standard of care or accepted practice?	Mild departures in documentation standards

• No departure. • Mild departure. • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Mrs	
Question 12: Whether the personal cares provided to Mrs was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	HQSC webinar 2023. Preventing and managing skin problems in the residential care setting https://www.hqsc.govt.nz/resources/resource-library/presentations-from-the-webinar-preventing-and-managing-skin-problems-in-the-residential-care-setting/
Advisor's opinion:	Expectations for the delivery of personal care are outlined in the organisation's Hygiene and Grooming policy and Personal Care and Hygiene Quiz (31 July 2024). The policy states (2A) 'Report any skin irritations, breaks, rashes, bruising or swelling to the senior person on duty'. The Personal Care and Grooming document discussed aspects of care delivery, noting the importance of 'patience and tailored care routines' Progress notes describe daily care occurring and entries suggest the care team knew Mrs well. While a recent InterRAI clinical assessment and LTCP care plan were submitted that identify personal care requirements, there is minimal evidence in progress notes to confirm that regular RN oversight of Mrs personal care needs occurred. InterRAI and care plan information discussed Mrs assessed abilities and level of support, with care plan evaluation noting that changes had been made to her plan of care in July/ August 2024. Skin care

	evaluation discussed perineal pain and redness with direction for daily skin checks, to apply prescribed creams, noting to inform an RN of signs of concern. Monitoring forms were supplied that show continence product changes and toileting opportunities. It appears that routine daily care was occurring and RNs alerted by carers about changes in skin integrity, which is in line with policy guidance. Given Mrs [redacted] history it would be recommended for RNs to regularly document assessment and care actions in the care record to reflect clinical oversight, as identified by the provider from audit feedback. From the evidence reviewed it appears that carers were attentive to Mrs [redacted] personal care needs. There are opportunities for improvement in RN documentation processes in the circumstances.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Organisational policies and supporting health resources discuss expectations for delivery of personal care.
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	Mild departure identified in documentation standards
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It would be viewed similarly by my peers.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Mrs	
Question 13: Whether Mrs [redacted] congestive heart failure was appropriately monitored. As part of this, please comment on whether Mrs [redacted] weight was monitored appropriately.	

List any sources of information reviewed other than the documents provided by HDC:	• HQSC Frailty Care Guides 2023. Heart Failure https://www.hqsc.govt.nz/resources/resource-library/heart-failure-manawa-he-frailty-care-guides-2023/
Advisor's opinion:	Clinical file information states that Mrs [redacted] medical history included congestive heart failure (CHF). Health resources describe CHF as a complex clinical syndrome. It is considered a chronic and progressive cardiac condition that can impact a person's health, wellbeing and quality of life. Symptoms may include shortness of breath, fatigue, dizziness, cough, lower limb swelling, weight gain. Supportive strategies may include medication management, regular weighs, vital sign and fluid balance monitoring per GP/NP orders and align with the resident's goals for care. It is recommended that care plans discuss the resident's long-term needs and CHF management and include personalised guidance to aid care interventions and decision-making. Mrs [redacted]s care plan provides discussion of cardiac care. Records state that goals for care were reviewed during GP/NP three monthly visits, and when unwell. Signs for carers to be aware of include fatigue, shortness of breath during activities and lower leg oedema. Medications to be administered as prescribed, vital signs and weight recorded monthly, or more frequently if unwell. Nutrition evaluation August 2024 stated that Mrs [redacted] had presented with recent weight loss (1.4kg) with daily weight monitoring implemented. Observations for signs of concern with sleeping patterns and change in respiratory function are discussed. Reviewed progress notes provide minimal discussion of weight recordings or indications for increased monitoring, with no evidence supplied of STCP. Progress note entries show that RNs were responsive during episodes of unwellness. Vital signs were recorded at 30min intervals with assessment of cardiac symptoms discussed (pain, dizziness, nausea, shortness of breath). Entries discuss the use of monitoring records, such as fluid balance charts, although not sighted in the supplied

	evidence. Weight charts were in use 2021-2024 although no trend analysis was evidenced. It is unclear whether clinical guidance was sought from the GP/NP regarding health and wellbeing concerns, such as weight changes, with minimal evidence of STCP used.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As outlined in supplied health resources
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure. • Moderate departure; or • Severe departure.	From the information reviewed it appears that systems were in place to monitor Mrs [redacted] for signs of weight changes and heart failure, however I am unable to provide further comment due to a lack of clinical information
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	Lack of supporting evidence to inform further comment
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Mrs [redacted]	
Question 14: Any other comments you wish to make.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	No further comments to add at this time.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure. • Mild departure.	