Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC01681)

Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report concerns a complaint from Ms A about the care provided to her son, Mr B, at Bupa Whangārei Rehabilitation — Pou Oranga (BPO) in June and July 2020. Ms A considered that her son's condition was deteriorating, and BPO was not monitoring or managing him appropriately. At that time, BPO was owned and operated by Bupa Care Services NZ Limited (Bupa).[1]

2. The following issue was identified for investigation:

- *Whether Bupa Care Services NZ Limited provided Mr B with an appropriate standard of care at Bupa Rehabilitation Whangārei — Pou Oranga between June and July 2020 inclusive.*

3. Having carefully considered all relevant information, the Deputy Commissioner found that Mr B did not receive the appropriate standard of care and treatment from BPO in a number of respects. In particular, BPO repeatedly failed to implement short-term care plans that were appropriate for Mr B's specific needs. The Deputy Commissioner concluded that these

[1] Bupa sold Bupa Care Services NZ Limited — Bupa Rehabilitation, which included BPO, in May 2021. As a result, the Whangārei facility was not involved in this investigation after that date.

Names have been removed (except Bupa Whangārei Rehabilitation — Pou Oranga, Bupa Care Services NZ Limited and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

failures in care represented a breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

4. The Deputy Commissioner also found that BPO breached Right 10(3)[3] of the Code, by failing to facilitate the fair, simple, speedy, and efficient resolution of Ms A's complaint about Mr B's care.

5. Independent advice about Mr B's care was obtained from Registered Nurse (RN) Richard Scrase (Appendix A).

Relevant background

6. At the time of events, Mr B was in his thirties. He had been a resident at BPO since 2018.[4] Mr B lived at BPO under a Manatū Hauora|Ministry of Health rehabilitation contract that aimed to 'support and promote [his] maintenance of function and independence'.

7. Mr B has spina bifida[5] and paraplegia[6] and mobilises using a wheelchair. He has an extensive medical history, including several complex urological issues and interventions, recurrent urinary tract infections (UTIs) and long-term use of an indwelling catheter (IDC).[7] Mr B lived in his own one-bedroom unit at BPO but required help from staff with most activities of daily life and transfers to and from his wheelchair.

8. Ms A was closely involved in her son's care at BPO. She complained that BPO failed to take appropriate action in relation to a stage three pressure injury[8] on Mr B's sacrum, which led to him being hospitalised with sepsis;[9] an unstageable[10] pressure injury on his left foot; and Mr B developing purple bag syndrome[11] from his indwelling catheter. Ms A said that BPO staff also did not arrange for Mr B's general practitioner (GP) to review him in these respects in a timely manner, or notice that he had no output from a new suprapubic catheter.[12]

[2] Right 4(1) stipulates: 'Every consumer has the right to have services provided with reasonable care and skill.'
[3] Right 10(3) stipulates: 'Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.'
[4] Mr B now lives elsewhere.
[5] A condition caused by the incomplete development of a baby's spinal cord and vertebrae before birth.
[6] Paralysis of the lower half of the body.
[7] A catheter inserted into the bladder via the urethra, which remains in place attached to a stoma bag to collect waste leaving the body.
[8] An injury to the skin and/or underlying tissue, usually over a bony prominence, due to pressure. Also known as a pressure ulcer or pressure wound.
[9] Sepsis is a medical emergency. It occurs when the immune system has an abnormal response to an infection and starts to attack organs and tissues, potentially leading to tissue damage, organ failure, and death.
[10] The stage of the wound cannot be classified as its depth cannot be determined.
[11] The urine in a catheter turns purple due to a chemical reaction between the urine and the bag/tubing. It is most commonly caused by prolonged catheterisation alongside a urinary tract infection.
[12] A catheter inserted into the bladder through a hole in the abdomen, which remains in place attached to a stoma bag to collect the waste leaving the body.

9. Ms A also complained that BPO did not respond to her complaint about Mr B's care or provide any explanations about the issues she raised.

10. The parties directly involved in the investigation were:

Ms A	Complainant
Mr B	Consumer

11. Also mentioned in this report:

RN C	Registered nurse
Ms D	Occupational therapist
Ms E	Facility co-ordinator
Ms F	Operations Manager — Rehabilitation

Key events

12. BPO staff, especially BPO's rehabilitation (rehab) coaches,[13] provided personal care and assistance to Mr B on a daily basis throughout June and July 2020. This included help with showering and dressing; skin and wound care; transferring to and from his wheelchair; changing his colostomy bag and reminders to empty his catheter bag; cleaning and laundry; turning over during the night; and getting to appointments and the shops. The district nursing service (DNS) also provided care for Mr B's continence, drains, and wounds in this period.

13. This section summarises key details in Mr B's care in June and July 2020 as they relate to the complaint.

June 2020

14. As at 1 June, Mr B had been back at BPO for nearly a month, having spent 10 days in the public hospital (the hospital) from the end of April with cholecystitis (inflammation of the gallbladder). Mr B still had a cholecystostomy drain in his side to remove infected and blocked fluid from his gallbladder. Mr B also had a sacral[14] pressure injury, which Bupa said he had acquired during his hospitalisation. The hospital discharge summary did not mention this injury; it appears to have been noticed by staff when Mr B returned to BPO. BPO's notes indicate that this injury may have developed from a healing pressure injury that Mr B had on his buttocks when he was admitted to hospital in late April.[15]

15. BPO's notes show that Mr B's sacral pressure injury was not infected, inflamed or painful, although there was a 'sore area higher up [his] back'. The notes also show that Mr B suspected he had a UTI. However, his temperature was recorded as normal at 37.5°C. Mr B was also concerned that the urine in his IDC bag was blue. A rehab coach telephoned a

[13] Staff who provided personal care, support, and encouragement to BPO clients.
[14] The sacrum is the large, triangle-shaped bone in the lower spine that forms part of the pelvis.
[15] On 14 April 2020, a BPO registered nurse started a wound initial assessment and plan chart for a 2cm-by-1cm pressure injury on Mr B's left buttock. Due to the passage of time, Bupa was unable to confirm that the 14 April 2020 pressure injury evolved into the subsequent 'hospital-acquired' sacral pressure injury.

district nurse and the BPO on-call registered nurse about the blue catheter bag but was only able to leave messages for them. There is no response to either phone message documented in the notes at that time or the next day.

16. Bupa told HDC that Mr B had a rehabilitation and support plan (rehab plan) to identify and promote his goals. Bupa said that the 'current or active health/medical concerns' in Mr B's rehab plan had been revised on 20 May to include his cholecystostomy drain and his catheter and the risk of pressure areas on his sacrum, bottom, and feet.

17. On 2 June, a rehab coach wrote 'purple bag evident' in Mr B's notes in relation to his catheter bag, although there is no indication that any action was taken towards reporting or investigating it. Mr B's wound evaluation chart stated that his pressure injury was not infected, inflamed or painful, but had a 'sore area at top centre some broken [skin]'. Mr B was noted to be reluctant to turn every two hours during the night to spend time off the broken skin on his buttocks. He said that this was due to discomfort from the cholecystostomy drain in his side (the drain was eventually removed at a hospital outpatient appointment on 5 June).

18. On 3 June, the wound evaluation chart for Mr B's pressure injury notes that its margins appeared healthy, and it was not infected or inflamed. BPO registered nurse RN C applied a sacrum Allevyn[16] dressing to the pressure area, with an Aquacel brand dressing 'on [the] small part' (understood to be the sore area near the sacrum wound).

19. On 4 June, a rehab coach recorded that Mr B's catheter bag was 'still slightly blue', possibly because it was an old bag.

20. On 5 June, Mr B was discussed at BPO's Monthly Health Clinic documented by RN C. On 10 June, Mr B was discussed at a BPO Clinical Team Meeting attended by RN C, Ms D (a BPO occupational therapist), and Ms E (the BPO facility co-ordinator). According to the notes, the focus of both meetings was on Mr B's cholecystostomy drain having been removed, his diet, and the activities he likes and those that he should be doing more often. Mr B's recent blue/purple catheter bag and his pressure injury were not mentioned as having been discussed in the notes of either meeting.

21. Mr B's pressure injury dressing was changed on 5, 12 and 13 June. On each occasion, a registered nurse applied a sacrum Allevyn dressing and an Aquacel dressing 'to the small opening'. The condition of the injury was unchanged on the wound evaluation chart, with healthy margins noted and no infection or inflammation. There was no mention of the wound having an odour. However, an entry from a rehab coach in the notes of 7 June states that Mr B's sacrum injury had an odour at that time.

22. On 15 June, a rehab coach documented that Mr B had a 'blueish mark in left [heel] sole area' and a nurse had been emailed 'to check [it] out'.

[16] An adhesive foam dressing specifically designed and shaped for use on the sacrum.

23. On the morning of 18 June, it was recorded that Mr B's pressure injury dressing had come off. A 'pad' was put on his buttocks area as there was no other dressing available. The DNS was telephoned to request a dressing change. In the evening, Mr B is documented as having 'commented to staff about the blue hue of his catheter bag'.

24. On 19 June, a rehab coach recorded:

> '[Mr B is] still concerned about blue bag. Thinks he should be on antibiotics. Can't check if it is bag that has been used for too long as he won't use the spare bags which have a twist opening. Dark area on left heel seems to be getting worse. I tell him not raising his legs is not helping. He feels somebody should be checking it out and putting a dressing on it.'

25. RN C documented that a district nurse visited to change Mr B's sacrum dressing and recorded a plan to 'clean [the wound] with [sodium chloride], [use] idosorb [ointment] to help with slough and Allevyn sacrum dressing'.

26. On 20 June, a rehab coach noted that Cavilon cream[17] had been applied to an apparent 'new discolouring in an area by [Mr B's] big toe'. RN C documented that the 'broken-down' areas on Mr B's sacrum were 'improving slightly' and that a district nurse would provide sacrum Allevyn dressings for it.

27. On 22 June, wound initial assessment and plan charts were started for three new pressure injuries: a 1cm-by-1cm injury on Mr B's left big toe; a 3cm-long injury on his left heel; and a 3cm-by-1cm-by-0.5cm injury on his 'lower back/scar line'. The notes show that Ms A was informed of her son's new pressure injuries, in addition to the DNS as the 'primary carers for [Mr B's] wounds'. RN C changed the dressing on Mr B's sacrum as per the district nurse's plan and noted that the wound 'remain[ed] unchanged'. She also put 'protector pads' on Mr B's left heel and left big toe.

28. On 24 June, RN C documented that she had emailed the registered nurse at Mr B's GP practice to make an appointment for him to see his GP. Although not documented, Bupa said that an appointment was booked for Mr B on 17 July as it was the next date available.

29. In the late evening of 28 June, Mr B said that he felt sick and sore on his right side. He took paracetamol overnight, as offered by a rehab coach, and said that he would monitor how he felt. The following day, 29 June, Mr B asked for his observations to be taken. He was reviewed by RN C, who found that he was a little lethargic and had a temperature of 38°C and intermittent pain in his lower right quadrant. RN C documented that Mr B's risk management action plan required that he be transferred to hospital if his temperature increased. The risk management action plan, which was last updated on 1 May, identified eight risks in total, including infection, pressure wounds, and risks relating to Mr B's urinary catheter.

[17] A durable, moisturising barrier cream.

30. At 4pm, an ambulance was called to take Mr B to hospital. His hospital notes state that he presented with fever symptoms, and said he had been unwell, fatigued and lethargic for two weeks, and had noticed that day that he had 'odd coloured' urine. Mr B was found to have sepsis secondary to his sacral pressure wound, plus a pressure wound to his left heel. He was later also diagnosed with renal tubular acidosis,[18] hypokalaemia,[19] and anaemia.[20]

31. On 29 June, Ms E, the facility co-ordinator, telephoned Ms A for an update about her son's condition in hospital. On 30 June, Ms E had another telephone conversation with Ms A. Ms E noted:

> '[Ms A is] unhappy that [Mr B] hasn't seen [doctor] or had bloods and has deteriorated again. Has been asking for weeks for him to be seen by [doctor]. Spoke at length.'

32. Ms E assured Ms A that she would investigate and get back to her. In a further telephone conversation later that day, Ms E documented:

> '[Ms A is] upset and frustrated that [Mr B] is so unwell, said he is lucky to be alive … [Ms A] wants people to listen to her. She says she knows when her son is not well and feels there is no urgency around his medical care.'

33. BPO's Family/Whānau contact record shows that Ms A continued to make frequent contact with BPO about her son's care and health.

July 2020

34. On 1 July, Mr B's protocols for activities or processes involving input from a number of different staff and/or family members were updated. Bupa said that such protocols support clients' independence and level of functioning and set out the consistent and best way for all staff to work. Mr B had eight protocols, including:

- Being turned from one side to the other at least twice overnight to prevent pressure areas developing;
- Flushing his catheter to ensure that it remains clean and he remains healthy. The protocol states that if the catheter bag becomes purple or blue, or there is any suspected blockage, a district nurse should be contacted; and
- Performing a urine analysis at least once a week and taking Mr B for an urgent GP appointment if the test results require it.

35. On 7 July, while he remained in hospital, Mr B had a suprapubic catheter (SPC) inserted by the Urology team. The procedure was initially scheduled for earlier in the year but had been

[18] An accumulation of acid in the body due to the kidneys failing to acidify the urine.
[19] Low potassium.
[20] A lower-than-normal number of the healthy red blood cells or haemoglobin (a protein) needed to carry oxygen to the body's tissues.

postponed due to the COVID-19 pandemic. It was noted to have been a 'very difficult' insertion due to scar tissue.

36. On 9 July, Mr B was discharged from hospital and returned to BPO. The hospital referred him to the DNS for future pressure injury dressing changes and monitoring of his SPC. The referral stated that Mr B had four pressure injuries: on his left great toe, right heel (this should have read left heel), right buttock, and sacrum. The referral did not mention the pressure injury BPO had documented on Mr B's lower back/scar line on 22 June, but the position of that injury[21] was such that it may have been considered part of the sacrum wound. Ms D, an occupational therapist, documented that BPO would follow up with the DNS about Mr B's wound care, put a short-term care plan in place for monitoring Mr B, and arrange weekly blood tests and a GP review.

37. Ms D spoke to Mr B about relocating from his unit to the main house at the facility for 'a few nights' so that he could be monitored more closely. That was BPO's 'recommendation and preference', but Mr B did not want to leave the familiarity of his unit. Ms A was made aware of her son's decision to remain in his unit. The short-term care plan for monitoring any decline in Mr B's health set out that his blood pressure, temperature, heart rate, and pain level should be taken every four hours.[22] Any signs of decline, such as increased temperature, abdominal pain, or purulent discharge from his SPC site, should be documented, and consideration given to calling an ambulance, and Ms A and the registered nurse should be advised.

38. On 10 July, a district nurse and a continence nurse visited Mr B. RN C's notes state that the district nurse updated the wound care plans for Mr B's five pressure injuries (sacrum, lower back, buttocks, left big toe, and left heel). It was agreed that the DNS would assess the injuries weekly and BPO would email photos of any changes to the injuries to the district nurse. The notes also state that a 'continence product [was] to be placed over for protection of [Mr B's] lower back, sacrum and buttocks'.

39. At 8.40am that day, RN C recorded that Mr B's SPC urine output was 500ml. At 12.30pm, however, RN C telephoned the continence nurse as a rehab coach had reported that Mr B was 'saturated right through' (with urine). There were also indications that his catheter bag was not filling up as his new SPC was blocked. It was agreed that Mr B should be transferred back to hospital, and an ambulance arrived to transport him there at 1.15pm.

40. The Emergency Department (ED) notes state that Mr B had noticed that his trousers were wet and that his catheter bag had not refilled since it had been drained that morning. The SPC blockage was resolved after an ED nurse detached and re-attached the catheter to take a urine sample. However, Mr B was found to have recurrent sepsis, potentially due to infections at the site of his SPC and his sacrum injury. The infections were treated with antibiotics. Mr B was also diagnosed with left-sided hydronephrosis (a swollen left kidney

[21] As shown on the BPO wound chart of 22 June 2020.
[22] Four-hourly checks were referred to in the BPO notes as 'QID obs'.

due to a build-up of urine) and acute kidney injury,[23] secondary to an obstruction (a kidney stone) in his left ureter.[24] A nephrostomy tube was placed in Mr B's left kidney to drain the urine, and he was advised that he would need to return to hospital in future to have the stone removed.[25]

41. On 22 July, Mr B was discharged from hospital and he returned to BPO. RN C documented that his sacral pressure injury was 'excoriated' (abraded) with 'small breaks around sacral area' at that time. Short-term care plans were started for any general decline in Mr B's health, for keeping his drain site infection free and aiding healing of his wounds, and for healing and reducing the risk of pressure injuries. The plan regarding pressure injuries detailed the type of surfaces Mr B should sit or lie on; how long he should sit or lie down for without changing position; how his skin should be assessed; how his continence and diet should be managed for good hygiene and nutrition; and the required communication and documentation.

42. On 24 July, a district nurse reviewed Mr B's wounds and updated the new pressure injury care plans.

43. On the evening of 27 July, a rehab coach contacted RN C with concerns that Mr B might have a catheter blockage as there was no output to either of his catheters. The rehab coach contacted Ms A and it was agreed that Mr B needed to go to hospital. He was re-admitted and remained in hospital until 1 August. During this admission, Mr B had his nephrostomy tube replaced as planned on 29 July.

Further information

District Nursing Service (DNS)

44. The DNS is part of Te Whatu Ora | Health New Zealand. Te Whatu Ora told HDC that any facility with its own registered nurses would be expected to manage its patients' continence and general wound care, including pressure areas. However, the DNS may provide care or advice where it is beyond that 'reasonably expected to be the domain of a nurse in [a given] facility', such as intravenous (IV) care, complex or extensive wound management requiring specific devices, or other complex care.

45. Te Whatu Ora said that Mr B's continence management was above the normal level of residential care due to his underlying conditions. The DNS assisted with his pre-arranged catheter changes and on-call 'troubleshooting'. It had total responsibility for Mr B's catheter management and expected a BPO nurse to make contact if an issue arose.

46. Te Whatu Ora advised that the DNS had taken on other aspects of Mr B's care over time, namely wound care and IV therapy. The DNS reviewed Mr B's sacral wounds and provided advice, support, and specialist dressings to RN C. Te Whatu Ora said that initially the DNS

[23] A sudden and often reversible reduction in kidney function.
[24] The ureters are two tubes that move urine from the kidneys to the bladder.
[25] A small tube that allows urine to drain from the kidney to a collection bag, through an opening on the patient's back.

visited every week to 10 days, but that increased to every three days 'as [Mr B's] sacral pressure area deteriorated'. The DNS had its own care plans for Mr B, and it expected that RN C also held BPO care plans for him and updated them in line with the specialist DNS reviews she attended.

ACC treatment injury claim

47. Ms A advised HDC that Mr B made a successful treatment injury claim to the Accident Compensation Corporation (ACC) for a May 2020 'sacrum pressure injury + infection + sepsis (grade 3)', and a June 2020 unstageable left foot pressure injury.[26] In considering Mr B's claim, ACC obtained clinical advice from a registered nurse, who advised:

> 'I could find no evidence of a care plan [relating to pressure injuries]. There is no Waterlow assessment, Braden score and no evidence of pressure relieving equipment such as a pressure mattress being used while in the rehabilitation unit. There appears to have been a failure to provide an appropriate assessment and treatment plan on admission which there should have been. Had this been done it is likely that some of the pressure injuries sustained could have been avoided.'[27]

Ms A's complaint to BPO

48. On 6 July 2020, Ms A made a complaint to Ms E about how Mr B 'ended up in hospital seriously ill with life threatening conditions'. Ms A stated:

> 'All the signs, the red flags were there weeks before [Mr B] went to hospital. The 11kg weight loss over … six weeks was huge, the fast-eroding wounds, [Mr B's] lack of appetite, his huge fatigue, his paleness, the purple bag syndrome, which is a rare phenomenon and is a bacterial infection, it didn't go away. Why at the very least was a urine specimen not taken to be cultured?
>
> [Mr B's] health has been severely neglected … [I]n every other aspect [Mr B] and myself totally respect what you [BPO] all do in building his independence but his health and well-being are of equal importance.'

49. Ms A said that from 21 May onwards, when Mr B developed a cough, she had been asking RN C and Ms D to take him to his GP and have blood tests done. She said that early blood tests would have revealed her son's infection, as his CRP[28] at hospital admission was very high at 320. Ms A was named as attorney in her son's Enduring Power of Attorney (EPA),[29] and she said she has a close relationship with him. Ms A said she knew that Mr B was not well, and she wanted BPO staff to listen to her, but she had been 'beating [her] head against a brick wall' because of 'the absolute lack of urgency displayed in seeking medical

[26] Mr B's claim was approved on 17 February 2021. An ACC treatment injury claim seeks financial cover for an injury alleged to have been caused to a patient by treatment from a registered health professional. A treatment injury is an injury that resulted in physical harm or damage to the patient, was caused by treatment, and is not a necessary part or ordinary consequence of treatment.
[27] Waterlow and Braden are risk assessment tools used to identify those at risk of developing a pressure ulcer.
[28] The C-Reactive Protein (CRP) blood test is a general test to check for inflammation in the body.
[29] Mr B's EPA was not activated at the time of the events.

intervention for [him]'. Ms A noted that he had to wait until 17 July for a GP appointment, and asked why Mr B was not booked into one of the medical centre's two daily emergency slots.

50. On 14 July, Ms A had a pre-arranged conversation about her complaint with Ms F, Bupa's Operations Manager — Rehabilitation. Their telephone conversation is not documented, but on 14 October 2020 Ms F wrote to Ms A as follows:

> 'I would like to sincerely apologise for the distress this situation has caused you and [Mr B], and for not providing a formal update after we had a discussion via phone on the 14th July 2020 … Please be reassured that we are committed to providing [Mr B] the best possible care and working in conjunction with you both to enable a positive experience for his rehabilitation journey in Whangārei Rehab.'

51. Ms A told HDC that she was unhappy with 'the way her complaint was managed and responded to'. She said that she was provided with 'a verbal response only from Ms E who acknowledged [she] had some valid concerns, however there were no explanations provided and no response received from [Ms F] who was emailed the complaint'.

52. Bupa stated that Ms A's complaint was not responded to in accordance with its complaints management process and acknowledged that Ms F did not respond to Ms A formally at the time.

53. Bupa conducted a clinical file review of the overall care provided to Mr B, in light of Ms A's complaint to HDC. The 14-page review, which included a number of recommended 'corrective actions', found the following:

> '• Documentation, assessment, care plans are incomplete.
>
> • Medication prescribing and administration does not follow both Bupa and professional standards.
>
> • Nursing assessment and risk management plans not updated when change in client condition or on return from hospital in a timely fashion.'

54. There is no indication in the available information that the review or its findings were shared with Mr B or Ms A.

Bupa's response to HDC

55. Bupa provided comments to HDC about Mr B's care at BPO during the time outlined above, including the following key issues.

Pressure injuries

56. Bupa acknowledged that the development of a short-term care plan for Mr B's pressure injuries would have allowed for greater care coordination and guidance for the rehab

coaches in between the care and oversight provided by the registered nurse and the DNS. Bupa stated:

> '[Bupa is] sorry that [the short-term care plan] was not completed … [T]his was identified by Bupa at the time [Ms A's] complaint was initially raised, and training and support was completed to ensure the registered nurse was aware of the importance of care planning thereafter.'

57. Bupa said it considered that the DNS 'had primary responsibility for the assessment and management of Mr B's wound care'. Bupa pointed out that Mr B was at BPO under an ACC rehabilitation contract aimed at supporting and promoting his maintenance of function and independence. Bupa stated:

> '[T]he additional supports required by [Mr B] with the development of pressure injuries fell outside of the normal level of care required by rehabilitation clients and beyond those that the team at [BPO] were able to provide.'

58. Bupa noted that it had identified that visiting health professionals had not always recorded their visits in Mr B's BPO records or provided their changes to his wound care plans to an appropriate BPO clinician. As a result, BPO's clinical records had not always included up-to-date care plans for Mr B. Bupa said that steps were taken to ensure that relevant care was captured in the BPO clinical file once that was discovered, but it did not state what the steps were.

In-dwelling catheter (IDC)

59. Bupa told HDC that Mr B has a complex urological history, including recurrent urinary tract infections and having an IDC for many years. Bupa said that in combination with his 'multifaceted comorbidities', this history meant that Mr B '[did] not always present with the usual signs and symptoms associated with urinary tract infections'.

60. Bupa stated that purple bag syndrome is an extremely rare condition. Bupa said that aside from the discolouration, 'the symptoms … can be similar to those seen in a urinary tract infection including increased spasms, autonomic dysreflexia,[30] fatigue, mild lower back pain or other aches, fever or chills, urinary leakage (causing the need to catheterise more often), nausea, headache, blood or sediment in the urine or cloudy or foul-smelling urine'.

61. A Bupa geriatrician had reviewed Mr B's file and advised:

> 'The purple discoloration per se is benign and needs no special treatment. If it is associated with a clinical infection, then appropriate antibiotic therapy is needed. If tubing is blocked or due for a change this can be changed recognising that changing the

[30] Autonomic dysreflexia is an involuntary nervous system overreaction to external or bodily stimuli, which is most commonly experienced by people with spinal cord injuries above the sixth thoracic vertebra. It is considered a medical emergency.

> catheter without need increases the risk of bacteraemia[31] and urinary tract infection. It occurs in people with chronic constipation or bowel issues and urinary cauterisation[32] who get an alteration in usual microbiological flora in the bowel. These bacteria produce substances which are absorbed, filtered through the kidneys and then react with the tubing to produce the purple colour. The risk of infection needs to be constantly monitored due to the ongoing risk of [Mr B's] IDC and complex urinary history.'

62. Bupa said that the team caring for Mr B had identified some 'red flags' in June 2020, namely lethargy and elevated temperature, and had 'appropriately followed the escalation plan … by attempting to contact the RN and DNS and continuing to monitor [Mr B's] condition while awaiting further direction'. Bupa stated that the potential development of purple bag syndrome was appropriately added to Mr B's risk management plan. It said that development of a short-term care plan would be expected to have been completed if a UTI had been diagnosed, to ensure that staff were aware of the monitoring and escalation processes to be followed.

Suprapubic catheter (SPC)

63. Bupa told HDC that it was 'sincerely apologetic that there was not better monitoring and oversight provided to Mr B which may have allowed for earlier detection and intervention to be provided' in relation to his blocked SPC.

64. Bupa explained, however, that 'no specific [hospital] discharge instructions were given to [BPO] staff that took into account Mr B's complex history ie. stones or strictures[33]'. Bupa said that although a handover occurred between Ms D and hospital staff, it did not include any baseline observations for Mr B during his hospitalisation, and there were no issues identified on the discharge summary. Bupa stated that Mr B was documented as having an elevated temperature when he returned to BPO on 9 July and was given paracetamol, which helped to lower his temperature.

65. Bupa noted that urine output is an important indicator of renal function and potential infection or change in a person's condition. Bupa said that when RN C checked on Mr B on the morning of 10 July, his SPC had drained 500ml of urine. This output met the 'generally recognised' minimum urine output of 30ml per hour, below which a medical review would be indicated. As Mr B's bed was found saturated, his SPC was potentially blocked, and RN C consulted with the continence nurse specialist for guidance on appropriate next steps.

Liaison/communication with GP

66. Bupa told HDC that its GP Health Visits policy required that all clients were 'seen at least six monthly by their GP, and more frequently if health concerns are raised at their monthly health clinic or there are prevailing health concerns'. Bupa said that Mr B attended

[31] Bacteria in the bloodstream.
[32] The use of a small electrical charge to stop bleeding.
[33] Strictures restrict the flow of urine from the bladder.

appointments with his GP at least every three months for a general health review, with additional reviews arranged as indicated or requested by any party in the interim.

67. Mr B did not see his GP between 12 March and 18 August. Due to the passage of time since the events, Bupa was unable to comment on why Mr B did not see his GP regarding his reported symptoms in early June. However, Bupa said that a GP appointment was requested for Mr B on 24 June, in response to a request from Ms A. Mr B's appointment was booked for 17 July, which was the medical centre's next available appointment date (ultimately Mr B did not attend this appointment as he was in hospital). Bupa said that it expected that any acute concerns or deterioration in Mr B's condition prior to the 17 July appointment would have resulted in BPO staff attempting to contact his GP again or sending Mr B directly to hospital for review.

68. Bupa noted that the hospital would be expected to send a copy of Mr B's discharge summaries directly to his GP. That being the case, Bupa said that his GP could have arranged to review Mr B further, 'especially considering the complexity of [his] condition'. Bupa said that it had escalated concerns to Te Whatu Ora and Mr B's funder about his placement at BPO, in terms of 'his actual care needs being greater than the support and care provided by [BPO]'. Bupa said that BPO 'attempted to have open conversations with [Mr B] and his mother regarding … the need to consider more suitable care options'.

Responses to provisional opinion

69. The provisional opinion was shared with Bupa and it was invited to respond with any further comments. Bupa advised that it accepted all the recommendations and would work to complete them.

70. Ms A was provided with, and invited to comment on, the sections of the provisional opinion comprising the information gathered in the investigation. Ms A acknowledged that Bupa had taken some responsibility for failings in her son's care but reiterated how 'traumatic' it was to watch him decline despite her advocating for him. Ms A said that Mr B's kidneys started to fail following the kidney injury and sepsis he experienced. As a result, Mr B had been receiving dialysis[34] for more than five hours a day, three times a week for the last 20 months. His left kidney was removed in April 2023 and Mr B is awaiting a date for surgery to remove his right kidney. Ms A said the removal of his kidneys would hopefully stop her son suffering further infections and episodes of sepsis. However, Mr B will then need to rely on dialysis for the rest of his life, unless he becomes eligible for a kidney transplant at some point. Ms A said that her son is inspirational, has a very strong character, and continues to 'beat the odds' due to his 'fierce will to live'.

[34] A treatment for kidney failure, where the recipient is connected to a dialysis machine that filters and cleans the blood over a period of time when the kidneys cannot.

Opinion: Bupa Whangārei Rehabilitation Pou Oranga — breach

71. I have undertaken a thorough assessment of the information gathered, guided by the independent advice I received from RN Richard Scrase.

72. In addition to the way BPO handled Ms A's complaint, I am concerned about several aspects of the care BPO provided to Mr B, namely the care planning in respect of his pressure wounds; the monitoring of his in-dwelling and suprapubic catheters; and the involvement of Mr B's GP in his care. I have set out my comments on each issue below.

Monitoring and care of pressure injuries

73. Ms A complained that BPO failed to take appropriate action in relation to the pressure injuries on Mr B's sacrum and left foot.

74. Due to Mr B's history of pressure injuries, it was especially important that BPO staff were vigilant about managing Mr B's risk of developing pressure injuries. He has impairments to his mobility, sensory perception, and activity due to his paraplegia and other health conditions. RN Scrase advised that these impairments represent three of the greatest risk factors for acquiring a pressure injury. Individuals with paraplegia or other spinal conditions, such as Mr B, are also particularly susceptible to pressure injuries, as they cannot feel sensation below a certain point and may not feel an injury in order to report it.

75. RN Scrase referenced New Zealand pressure injury prevention and management standards issued by ACC,[35] the New Zealand Wound Care Society,[36] and Te Tāhū Hauora|the Health Quality & Safety Commission.[37] He stated that a documented risk assessment and individualised prevention plan is a key factor in the prevention and management of pressure injuries. BPO identified the risk of pressure injury in Mr B's risk management action plan and his rehab plan, and in one of his protocols. It also sought regular external support and advice from the DNS in caring for his wounds. However, RN Scrase said that BPO did not have a 'clear, cohesive' short-term care plan for Mr B's pressure injuries until 22 July. RN Scrase stated:

> 'A short-term care plan is more than an exercise in documentation if used appropriately. It indicates cohesive critical thinking which should be revisited regularly and changed if necessary. It also means that those staff new to the facility would have a clear idea of what was expected to manage this.

[35] ACC, Guiding principles for pressure injury prevention and management in New Zealand, 2017. https://www.acc.co.nz/assets/provider/pressure-injury-prevention-acc7758.pdf
[36] New Zealand Wound Care Society, Pan Pacific clinical practice guideline for the prevention and management of pressure injury, 2012. https://www.nzwcs.org.nz/images/publications/2012_AWMA_Pan_Pacific_Abridged_Guideline.pdf
[37] Health Quality & Safety Commission, Frailty Care Guides: Skin wounds, 2019. https://www.hqsc.govt.nz/assets/Our-work/Improved-service-delivery/Aged-residential-care/Publications-resources/Skin_wo unds.pdf

> [T]here is an important difference between the wound management plan and a short-term care plan for pressure injuries. Although important, the former is purely about managing and dressing the wound. The latter has a more holistic approach and considers the wound, positioning, diet and mobility.'

76. Similarly, ACC's clinical advisor saw 'no evidence' of a pressure injury care plan for Mr B.[38] She attributed this to BPO's apparent 'failure to provide an appropriate assessment and treatment plan on admission[39] which there should have been'.

77. I am critical of BPO's delay in implementing this care plan. The delay is notable given that Mr B was recognised to have had a pressure injury on his buttocks since 14 April. That injury, or an injury in that general area, persisted on his buttocks or sacrum after he left hospital on 5 May. It was still present at the beginning of June when Ms A began to become concerned about Mr B's overall health. On 22 June, Mr B was recognised to also have pressure injuries on his left heel, left big toe, and lower back. However, a short-term care plan to manage his pressure injuries was not implemented until 22 July.

78. I acknowledge that BPO apologised that a short-term care plan was not put in place at the appropriate time and recognised that a plan would have assisted the rehab coaches to provide consistent care for Mr B in that respect. BPO did not explain why this failure occurred in its Clinical File Review or its responses to HDC.

79. BPO frequently referred to the DNS as the 'primary carers' for Mr B's wounds. However, the fact that the DNS was providing external wound care support for Mr B did not negate the need for BPO to put a short-term pressure injury care plan in place for him much earlier. The DNS confirmed that it reviewed Mr B's sacral wounds, in addition to providing advice, support, and specialist dressings to RN C, and it expected its advice to inform and update BPO's own care plan for Mr B. The DNS's expectation is consistent with RN Scrase's advice that a short-term care plan should be holistic and take account of wounds, positioning, diet, and mobility. As BPO was responsible for supporting and caring for Mr B full time, only BPO was in a position to create a short-term pressure injury care plan that encompassed all the necessary aspects of Mr B's life. I consider that ultimately BPO, not the DNS, was responsible for the provision of wound care support to Mr B.

80. RN Scrase said that the 22 July short-term care plan was 'holistic' and 'well-considered'. It provided staff with clear guidance about how to manage Mr B's pressure injuries and reduce the risk of further pressure wounds, by being alert to the surfaces he sat or lay on and ensuring that he changed position regularly, including elevating his heels on pillows. It also detailed all the aspects required in a skin assessment, including a Braden score, and to whom and when to escalate concerns. RN Scrase noted that this care plan seemed to have been effective by September 2020.

[38] However, it is accepted that a short-term pressure injury care plan was put in place on 22 July 2020.
[39] 'Admission' is understood to refer to Mr B's return to BPO after discharge from hospital on 5 May 2020.

81. Unfortunately, BPO staff did not have the guidance of this short-term care plan in June or the majority of July. It was only put in place when Mr B was discharged from hospital on 22 July, after being treated for 'pressure sores on [his] feet' and the infected sacral wound that led to him developing sepsis (amongst other conditions). Prior to 22 July, the pressure injury care Mr B received was not specifically prescribed and monitored to the extent that it would have been under a short-term care plan that aimed to heal, and prevent, pressure wounds. For instance, pressure injuries on the heels are amongst the most common pressure injuries for people who need to spend significant time lying down or in one position. RN Scrase said that this is another area where close monitoring is required. The short-term care plan specified that an individual's heels should be elevated on pillows to mitigate the risk. However, BPO's rehab coaches did not receive that guidance until weeks after Mr B first began showing signs of the pressure injury on his left heel on 15 June.

82. RN Scrase also referred to the incident on 18 June, when an incontinence pad had to be used on Mr B's sacrum injury as no other dressing was available; he said that scenario 'confirms the importance of having a clearly defined care plan where appropriate dressings would be ordered and [readily] available'. RN Scrase also noted gaps in the June wound evaluation records, particularly in terms of staff failing to document the size of Mr B's sacrum wound and only entering a one-word description of its condition.

83. RN Scrase considered that BPO's delay in starting a short-term care plan for Mr B's pressure injuries represented a moderate departure from the accepted standard of care. I accept this advice. In my view, BPO failed to implement this fundamental tool to manage and monitor Mr B's pressure areas at the appropriate time. Based on RN Scrase's advice and that obtained by ACC, it is reasonable to conclude that Mr B may have received more timely and consistent care for his sacral injury if a care plan had been put in place earlier.

Monitoring of indwelling catheter

84. Ms A complained that BPO failed to take appropriate action when the urine in Mr B's catheter bag began to turn blue and/or purple in early June 2020.

85. The DNS told HDC that it was responsible for Mr B's catheter changes, and RN Scrase noted that the district nurses came in frequently to carry out those changes. BPO had a key role, however, in monitoring Mr B's catheter for signs of possible infection. Mr B had a long history of UTIs, and his risk of infection was heightened due to his long-term use of a catheter. This meant that appropriate monitoring and documentation were vital, and clinical concerns should have been escalated accordingly. RN Scrase said that monitoring and documentation are particularly important with clinically complex clients such as Mr B, as any one of several different issues could potentially be the source of a complication or infection.

86. Based on RN Scrase's advice, it is my view that BPO lacked a clear plan in relation to monitoring and responding to Mr B's blue/purple catheter bag and his risk of urinary infection in June. BPO's risk management plan for Mr B stated that a purple or blue catheter bag was an early warning sign of a urinary problem. Yet BPO was slow to respond when, on

1 June, Mr B developed a blue bag and said he thought he had a UTI. A rehab coach was concerned enough to phone the district nurse and the on-call registered nurse to report it, but the notes do not show evidence of any specific follow-up at that point. In the following days, the notes contain several further references to Mr B having a blue or purple catheter bag. While Mr B then appeared to improve for a time, on 19 June he said that he felt he needed antibiotics.

87. The most recent short-term care plan for Mr B in relation to the management of a UTI was implemented by BPO in January 2020 (when he previously had a UTI). Short-term care plans are intended to be time-limited in order to resolve particular issues. As such, the January UTI care plan was no longer relevant in June 2020. BPO did not implement a new short-term care plan regarding UTI until September 2020. RN Scrase viewed that as a moderate departure from the accepted standard of care. I agree.

88. I am critical that BPO did not have a clear and cohesive plan in place to monitor Mr B for a possible UTI from 1 June onwards. I note that BPO stated that a short-term care plan would have been implemented if Mr B had developed a UTI. However, in my view, several red flags were documented in June, which should have prompted BPO staff to consider and/or take action regarding possible infection: Mr B's catheter bag was blue/purple at times, he was pale and lethargic, and said he felt that he had a UTI and eventually that he should be on antibiotics.

89. Without a short-term care plan in place to monitor and respond to Mr B's risk of developing a UTI, there was no guidance for BPO staff about, for instance, when Mr B's GP should be contacted about his catheter or how Mr B's belief that he should be treated with antibiotics should be managed and who should be contacted about it. The absence of this particular short-term care plan was despite Mr B being known to be susceptible to UTIs and several of his symptoms and statements during June indicating that such a plan should be implemented.

90. It is also concerning that, regardless of the lack of a short-term care plan, staff did not respond to the red flags that arose for Mr B and escalate them appropriately. In this respect, it is notable that Mr B's catheter bag was observed to be blue and/or purple several times without effective steps being taken to ensure that a registered nurse reviewed the situation without delay.

Monitoring of suprapubic catheter

91. Ms A raised concerns that BPO staff failed to notice that Mr B had no output from his new SPC when he returned to BPO from hospital on 9 July 2020.

92. First, I am critical of BPO's comment that the hospital discharge instructions failed to state that Mr B's urine output should be monitored following the insertion of his SPC. I concur with RN Scrase's advice that the BPO healthcare staff could have been expected to use critical thinking in the circumstances, rather than 'replicating' what was written on Mr B's discharge summary. As the BPO staff managing Mr B were aware of his history of UTIs and

blockages, it should have followed that his urine output was monitored closely due to his new SPC. RN Scrase stated:

> 'When an individual has had a procedure and the discharge summary explicitly states … "if becomes unwell with fever/abdo pain/purulent discharge from SPC site, then will need an urgent CT abdomen" there would be an expectation that urine output is also monitored closely. In situations such as this the expectation would be that the urine bag is emptied as soon as possible after arrival back at the new location (in this case [BPO]) so that it was totally clear what the ongoing urine output was after arrival.'

93. Unfortunately, the documentation does not provide a clear understanding of Mr B's urine output at BPO on 9 and 10 July. There is only one entry in this respect, which states that Mr B's urine output was 500ml on the morning of 10 July. RN Scrase said that this information lacked context as there was no record of the time period over which the 500ml of urine was recorded or how much of it was already in the bag when Mr B returned from hospital. As a result, it is not possible to establish whether or not Mr B had a reasonable urine output after he returned to BPO. RN Scrase advised:

> 'Given that a short-term care plan was commenced "To monitor for any decline in [Mr B's] health on return from hospital in first 24 hrs", I would consider it an omission that urine output was not considered to be an important part of this monitoring.
>
> … [T]his omission is in my view even more significant given that the reason for this observation was specifically because [Mr B] had an SPC recently inserted. I therefore consider this to have been a moderate departure from accepted practice.'

94. I acknowledge that Bupa apologised that Mr B did not receive 'better monitoring and oversight … which may have allowed for earlier detection and intervention to be provided'. Due to the lack of documentation, RN Scrase could not determine whether Mr B's blocked SPC could have been identified earlier, although he noted that BPO responded to the blockage in a reasonable timeframe once it was identified.

95. BPO's failure to include the monitoring of urine output in the short-term care plan that was put in place on Mr B's discharge from hospital on 9 July is concerning. RN Scrase said that urine output would be expected to be recorded 'as a matter of course' in the circumstances. By that point Mr B had been a resident at BPO for more than 18 months, and his complex urological history was well known. These factors alone should have prompted the BPO staff managing his care to monitor the output of his new catheter carefully.

Escalation of care to GP

96. Ms A raised concerns that when Mr B began to appear unwell, BPO staff did not arrange for his GP to review his symptoms promptly.

97. RN Scrase advised that GPs are an important part of healthcare provision for individuals living in a community setting. For clinically complex individuals such as Mr B, it is accepted

practice for the GP to be 'closely involved with providing necessary support to both the individual and the facility'.

98. RN Scrase identified several instances where it would have been appropriate for BPO to have involved Mr B's GP more, either for escalation or increased clinical oversight. I agree that was the case. While recognising that Mr B's 17 July GP appointment did not go ahead due to his hospitalisation, Mr B did not see his GP at all in June or July, and in fact was not reviewed for nearly five months between 12 March and 18 August. This is significant as Mr B was not only due for his three-monthly GP review in June, but he had a number of concerning symptoms from the beginning of that month that warranted escalation to his GP. He was documented as being pale and lethargic and concerned about his blue catheter bag on 1 June, and having an ongoing cough and feeling that he should be taking antibiotics on 19 June. Staff also documented that Mr B's bag was purple on 2 June and blue on 4 June.

99. It is unclear why BPO did not take action to arrange a GP appointment for Mr B until 24 June, when Bupa said Ms A specifically requested that her son see his GP. Bupa's GP Health Visits policy states that clients should be seen by their GP more frequently than their regular reviews '[if] there are prevailing health concerns'. That applied to Mr B from the start of June, and it is clear that Mr B recognised that himself. RN Scrase clarified that the fact that a 'concern may not have deteriorated further at the time does not in itself mean that the GP should not have been made aware' of it by BPO. He stated that BPO's failure to alert the GP to Mr B's symptoms was a moderate departure from the accepted standard of care. I accept RN Scrase's advice. Given Mr B's developing symptoms, his complex underlying health issues, and the potential for his condition to deteriorate rapidly, BPO should have liaised more closely with his GP about his reported symptoms.

100. As an aside, I note that RN Scrase advised that Mr B's GP also did not appear to be involved in discussions about Mr B at BPO's monthly health clinics. RN Scrase said that 'for someone as clinically complex as [Mr B] this may have been useful in terms of clinical oversight and more of an interdisciplinary perspective'. RN Scrase acknowledged, however, that including Mr B's GP at such meetings may have been unrealistic. He said that possible alternatives were to seek the GP's input for the clinic or make an entry in the notes to confirm that the GP had been made aware of the monthly health clinic discussion. Either option would have seen BPO liaise with Mr B's GP more and enabled the GP to be involved or ask questions about Mr B's care as necessary. There is no indication in the notes that Mr B's GP was informed about the monthly health clinic discussions relating to Mr B.

Complaint handling

101. Ms A complained that BPO did not respond to her complaint about Mr B's care or provide any explanations about the issues she raised.

102. BPO's complaint handling process was set out in its November 2019 Complaints Management Work Instruction (the work instruction).[40] The intention of the work

[40] Applied in conjunction with the overall Bupa ANZ Complaint Management Standards and Guidance.

instruction was to 'enable the identification and management of complaints using a consumer-focused process that is fair, accessible, efficient, confidential, and achieves resolution'. The work instruction further states that a complaints management process must support, amongst other things, 'action to be taken as soon as possible' and 'explanations and apologies [to be] readily provided'.

103. It is clear that BPO did not handle Ms A's complaint in accordance with the work instruction. BPO has itself acknowledged that. Ms F wrote to Ms A three months after discussing her complaint by telephone, but her letter did not deal with any of the specific issues Ms A raised about Mr B's care and support. Ms F's only reference to the complaint was to advise Ms A to be reassured that BPO was committed to providing Mr B 'the best possible care and working in conjunction with you both to enable a positive experience for his rehabilitation journey'.

104. I am critical of Ms F's response, as it does not reflect an understanding of Ms A's very real concerns or her right to make a complaint and receive an appropriate timely response to it. While Ms F spoke to Ms A about her complaint, there is no record of what was discussed and whether Ms F provided any appropriate explanations during the conversation. On balance, however, this appears unlikely. Ms A was dissatisfied that 'no explanations [were] provided', and BPO itself admitted that Ms A's complaint 'was not responded to in accordance with its complaints management process'.

105. As such, while Ms A received verbal and written responses to her complaint, I consider that these responses were insufficient, particularly given the complexity of the matters complained about. I am also critical that BPO did not take the opportunity to share the outcome of its Clinical File Review of Mr B's care with Ms A once it became available.

Conclusion

106. In my view, BPO failed to provide services to Mr B with reasonable care and skill for the following reasons:

- BPO did not implement a short-term care plan for managing Mr B's existing pressure injuries and his risk of developing pressure injuries until 22 July 2020.
- In June 2020, BPO failed to implement a short-term care plan for monitoring and responding to Mr B's risk of a UTI, despite his documented symptoms.
- In the short-term care plan implemented on 9 July 2020, BPO failed to specify that the urine output from Mr B's SPC should be monitored.
- In June 2020, BPO did not ensure that Mr B had his three-monthly GP review or make his GP aware of his documented symptoms.[41]

[41] Pale, feeling unwell and lethargic, had a cough, a blue/purple catheter bag and felt he needed antibiotics.

107. As a result, Mr B did not receive the standard of care and treatment he was entitled to from BPO in June and July 2020. In particular, BPO repeatedly failed to implement short-term care plans that were appropriate for Mr B's specific needs.

108. Accordingly, I find that BPO breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

109. In addition, I find that BPO breached Right 10(3) of the Code, as it failed to facilitate the fair, simple, speedy, and efficient resolution of Ms A's complaint.

Changes made since events

110. Bupa told HDC that several 'areas for strengthening' were identified in response to Ms A's complaint and HDC's investigation, including:

a) The implementation of specific additional education in complaints management, documentation, medication prescribing and administration, brain injury (by the Brain Injury Association), wound management (by DNS), continence management (by DNS), and mental health (by an external provider).

b) The Bupa National Clinical Service Improvement team were to provide further education to the facility coordinator regarding complaint management and maintain ongoing support and development in relation to complaint and feedback management.

c) The Bupa Operations Managers, including Ms F, attended a session on 26 August 2020 to discuss roles and responsibilities in complaint management.

d) Bupa employed Regional Quality Partners to focus on enabling care home managers, facility co-ordinators, and clinical managers to deliver continuous quality improvement and excellent clinical care in their homes and rehabilitation facilities.

Recommendations

111. In making the following recommendations, I have taken into account that Bupa sold its rehabilitation facilities, including BPO, to another provider more than two years ago. As a result, there is no scope to make recommendations towards systemic improvement.

112. I recommend that Bupa (on behalf of BPO) provide:

a) A formal written apology to Mr B for the breaches of the Code identified in this report in respect of his care at BPO. The apology should be sent HDC, for forwarding to Ms A (on behalf of Mr B), within three weeks of the date of this report.

b) A formal written apology to Ms A for the breach of the Code identified in this report in respect of BPO's handling of her complaint. The apology should be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

c) A full summary of Bupa's 19 October 2020 clinical file review of Mr B's care to Ms A, in lieu of the response to her complaint to BPO of 6 July 2020. The clinical file review

summary should be sent to HDC, for forwarding to Ms A, within six weeks of the date of this report.

Follow-up actions

113. A copy of this report with details identifying the parties removed, except Bupa Whangārei Rehabilitation — Pou Oranga, Bupa Care Services NZ Limited, and the advisor on this case, will be sent to Whaikaha, Te Whatu Ora, and HealthCERT and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Richard Scrase:

> 'Thank you for the request to provide clinical advice regarding the care provided [to] [Mr B] at Bupa Whangārei Rehabilitation. In preparing the advice on this case, I am not aware of any personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I started my nursing career in 2000 as a Nursing Auxiliary at Torbay Hospital in Devon, UK. After completing my Nursing Diploma, I started work in 2005 as a Registered Nurse on an acute surgical ward at Torbay Hospital in the UK. In 2006 I moved to New Zealand and worked at Christchurch Hospital on an acute colorectal and general surgical ward. I transferred to Older Persons Health in 2009 and worked as Registered Nurse on a rehabilitation ward before moving across to the Community Team at Older Persons Health in Christchurch which included working as an RN in a newly formed early supported discharge team. Following this I became a Gerontology Nurse Specialist in 2013 in a role that supported Aged Residential Care Facilities with areas such as clinically complex residents, education, and care planning support.
>
> In 2018 I was appointed as Nursing Director Older People — Population Health for Canterbury and West Coast DHBs. This role focuses on supporting nursing in both the Community and Aged Residential Care settings whilst continuing to be direct Line Manager for the Gerontology Nurse Specialist Team. It also involves investigating and reporting on any complaints and concerns raised to the Canterbury DHB and West Coast DHBs about care provided in local Aged Residential Care Facilities. In addition to this I have completed my post graduate diploma in Gerontology Nursing, and I have been an author on five published peer reviewed articles focusing on health-related issues in New Zealand's frail older population. I was part of the national group that has been formulating the ARC Covid Response Plan for New Zealand. Until recently, I was also Chair of the HQSC National ARC Leadership Group.
>
> The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr B] by Bupa Whangārei Rehabilitation was reasonable in the circumstances and why. The time period in question is, 1st May 2020 to the 31 July 2020.
>
> <u>I have specifically been asked to provide comment on:</u>
>
> 1. The management of [Mr B's] sacrum pressure wound injury that became infected and resulted in grade 3 sepsis.
> 2. The management of the pressure injury on [Mr B's] left foot (unstageable).
> 3. The treatment of [Mr B's] purple bag syndrome. Were there indicators for a different treatment path that could and should have been taken?

Names have been removed (except Bupa Whangārei Rehabilitation — Pou Oranga, Bupa Care Services NZ Limited and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

4. The management of [Mr B's] suprapubic catheter. Whether the issues with [Mr B's] catheter were identified within a reasonable time period? Please comment on the reasonableness of the care provided.
5. The timeliness of [Mr B's] assessment and escalation to a General Practitioner.
6. Any other matters in this case that you consider warrant comment.
7. The adequacy of policies/procedures.

For each question, I am asked to advise on:

a) The standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe)?

c) How would it be viewed by my peers?

d) Recommendations for improvements that may help to prevent a similar occurrence in the future.

As required by the Commissioner, I have looked to provide an objective opinion on the questions posed. Furthermore, as laid down in the Guidelines for Independent Advisors, where there are conflicting versions of events, I have endeavoured to objectively consider and comment on these differing perspectives.

When quoting relevant passages from documentation, I may not have quoted every passage relating to a specific issue, but in my professional opinion what I have quoted captures the essence of a specific issue as it appears in the documentation.

In reviewing this case I have endeavoured to view the events as they unfolded because the outcome was not known at the times that decisions were made. Furthermore, I have considered the action with respect to each event rather than the outcome since good practice can still result in a poor outcome and vice versa.

In examining this case, I have referred to the following documentation:

1. The copy of the referral of the complaint from the Nationwide Health and Disability Advocacy Service received on 14th September 2020.
2. Bupa Whangārei Rehabilitation response dated 16th October 2020.
3. Clinical records and relevant supporting documentation from the facility covering the period 1st May 2020 to 31 July 2020.
4. Clinical records from [the] District Health Board covering the period in question.

The Appendix has a summary of some of the key events as taken from the documentation provided. I have utilised this information in order to provide context

and in order to get a sense of the differing time frames with respect to the events discussed.

Background

[Mr B] was a resident of Bupa Whangārei Rehabilitation. He had spina bifida and was paraplegic and wheelchair bound. He had an extensive medical history including femoral fractures, recurrent UTIs and cholecystitis which required the insertion of a biliary drain. In addition, [Mr B] had a catheter and a stoma bag and had multiple urology and spinal surgeries. He had a hospital admission on the 29th June 2020 where a treatment claim was made for a pressure injury on his buttock and also on his left foot. The sacral pressure injury would become infected and resulted in grade 3 sepsis.

1. The management of [Mr B's] sacrum pressure wound injury that became infected and resulted in grade 3 sepsis.

Review of documentation

I have reviewed the documentation provided including the facility notes and the hospital documentation provided.

The facility documentation has Risk Management Action Plans that specifically mentioned pressure injury prevention and the actions that need to be taken to avoid pressure injuries, including position changes.

Review of the documentation highlights that the client was in isolation for 14 days following his discharge from hospital on 4th May 2020. This was at the time a common and reasonable precaution in residential care facilities where people are living in close proximity, in response to the Covid-19 pandemic. However, it may have made the monitoring of [Mr B's] skin and pressure injury prevention more challenging because any visit to his unit would have needed to be very intentional particularly with the requirement for the need for the wearing of full PPE.

My review of the facility notes indicated that the first time that any potential issues were identified with [Mr B's] skin on his buttocks was 14th April 2020. It was also noted that the skin in this area had deteriorated following his discharge from hospital on 4th May 2020. There were frequent references to [Mr B] being reluctant to stay on his side in order to keep his weight off his sacral area in both the hospital notes and the facility notes throughout the period under review.

The Occupational Therapist documents from the beginning of 2020 about a referral for a wheelchair assessment and the need for a different wheelchair. Meanwhile it is documented that staff "continue to monitor client's positions in wheelchair and encourage pressure management strategies to client" (16/1/20 Clinical Notes).

A wound assessment plan documents a wound on his left buttock on 14th April 2020 with an estimated healing time of one week. I could not identify a short-term care plan

for this wound. However, on the 18th April 2020, the wound was reviewed by a District Nurse who appears to have made changes to the plan.

Examination of the wound evaluation documentation has a number of areas that were incomplete and also sections that appeared inaccurate or lacked important information. For example, the wound care documentation on the 16th April 2020 documents a wound size of 1mm x 0.5mm and it being covered with a pad and also the use of cavilon cream. Subsequently there is mainly just reference to the use of cavilon cream with little or no reference to the size of the wound or its condition except that it appeared to be "healing" or "improving". The next recorded dimension of the wound was then 24 June 2020 with a wound size of 1cm x 1.5cm x 4cm. On 7th June 2020 the Progress Notes state that there was "an odour coming from that area" (the sacrum dressing).

The Clinical Notes on 10 July 2020 give an extensive summary of the wound care requirements for the pressure injuries on his sacrum, heal and toe but this does not appear to have been transferred to the wound care chart.

The hospital admission summary dated 10 July 2020, refers to his previous admission on 29 June 2020 with sepsis secondary to pressure sores at heel and sacrum. They also note that the District Nurses had been changing the wound dressings daily and have reported no concerns.

What is the standard of care/accepted practice?

Although recently updated the Health and Disability Service Standards and in particular Health and Disability (Core) Standards NZS 8134.1:2008 apply throughout this case (1). In terms of pressure injury prevention and management the key documents I have referred to are, the Accident Compensation Corporation, guiding principles for pressure injury prevention and management in New Zealand (2), the New Zealand Wound Care Society. 2012. Pan Pacific Clinical Practice Guideline for the prevention and management of pressure injury (3), and the New Zealand Frailty Care Guidelines which although intended for a different cohort (namely the frail elderly), the principles remain the same in the case of pressure injuries (4). Work is also underway specifically with respect to pressure injury prevention in those with spinal cord injury, but this is currently at the consensus statement stage with no firm guidelines that would have been available at the time of this event (5).

A pressure injury (also known as a "pressure ulcer" or "bedsore") is a "localised injury to the skin and/or underlying tissue, usually over a bony prominence, because of pressure, or pressure in combination with shear, and in most case, pressure injuries are preventable" (2).

However, the aforementioned documents also refer to pressure injury management in the event that a pressure injury has developed whilst the HQSC state that "Pressure injuries are often avoidable" (6). Therefore, under some circumstances, pressure

injuries cannot always be avoided despite appropriate interventions and assessments, (7).

A key factor in the prevention and management of pressure injuries is documented risk assessment and the implementation of an individualised prevention plan. Risk assessment includes consideration of both patient and environmental factors that are associated with the development of PIs (2). Among the biggest risk factors for an individual acquiring a pressure injury are impaired mobility, impaired sensory perception and impaired activity (3). All of these were to varying degrees factors that were experienced by the client in question.

In view of the guidelines and evidence mentioned above, I have reviewed this aspect of the concerns raised, from the perspective of what documented evidence of risk assessments and what interventions were put in place both to prevent pressure injuries and to manage them appropriately once they arose.

It must be noted however, that this client had a number of complex issues that were occurring at the same time. This would in my view have made treatment of all of these challenging at times because of differing management strategies. For example, management of the cough and the client's breathing was in part managed by ensuring the client sat more upright. This in itself would have created more weight and therefore risk of further damage to the pressure injury on his buttock even with appropriate dressings and pressure relieving equipment.

If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe)?
Review of the documentation highlights to me that the clinical staff at the facility were aware of the risk of pressure injury to this client and that they identified the pressure injury on his buttock in a timely manner. Furthermore, there is clear evidence that they sought further advice and input from the District Nurses who visited on a number of occasions including on 22 June 2020. It was also documented on numerous occasions in both the hospital and the facility, the client's reluctance to spend time off the broken area on his buttocks. There were times when this was because the drain area on his flank was uncomfortable and with little or no feeling in his lower limb area, the need to take pressure off the buttock area would not necessarily be as apparent as it would be for those that would be more able to feel any discomfort because of a pressure injury in this area.

My professional opinion is that the facility put in place some reasonable interventions at the time the pressure injury was developing and as it progressed, but were challenged by the fact that the client understandably wished to spend time sitting upright. However, what was lacking was a clear cohesive plan in the form of a short-term care plan. I was unable to identify a short-term care plan for this injury earlier than 22nd July 2020. This specific plan though was holistic and covered turns, wound care and nutrition for example. It also stated that there would be a period of bed rest twice a day

and stipulated the number of turns both during the day and at night. This was in my view a good and well considered care plan and it appears that the wound healed on the 7 September 2020, according to this document, so it seemed that the plan worked. A short-term care plan is more than an exercise in documentation. If used appropriately. It indicates cohesive critical thinking which should be revisited regularly and changed if necessary. It also means that those staff new to the facility would have a clear idea of what was expected to manage this or any other issue. As the name suggests, a short-term care plan should be time limited. This then means issues are more likely to be proactively addressed and plans revisited if there is no improvement. If a care plan such as this was in place earlier on when the pressure injury was first identified, it may have addressed the developing issue and avoided the complications and subsequent hospital admission.

I acknowledge that the facility were taking action, that they were getting external support from District Nursing and that the client was at times apparently reluctant to remain off his affected area. That said, it would appear the same issues were present after the last hospital admission and the application of the care plan which appeared to successfully address the issue with a holistic lens. In my view there is an important difference between the wound management plan and a short-term care plan for pressure injuries. Although important, the former is purely about managing and dressing the wound. The latter has a more holistic approach and considers the wound, positioning, diet and mobility.

There was one specific area of significant concern when reading the notes, namely the use of a pad when no dressings were available on the 18th June 2020. It was not entirely clear but the matter appears to have been addressed reasonably quickly as it wasn't mentioned again. In my view this confirms the importance of having a clearly defined care plan where appropriate dressings would be ordered and available. However, when considering this matter overall, I consider that there has been a moderate departure from accepted practice.

How would it be viewed by my peers?
I acknowledge that some of my peers may consider that a hospital admission involving a grade 3 pressure injury must have involved severe departure from accepted practice on the part of the facility. However, review of the documentation and the circumstances at the time the events occurred would in my view result in my peers agreeing with my summary.

Recommendations for improvements that may help to prevent a similar occurrence in the future.
My recommendations would be to highlight to staff the importance of short-term care plans. Furthermore, it is important that all staff have appropriate education with respect to pressure injury prevention particularly in terms of having a good understanding of how quickly they can develop.

2. The management of the pressure injury on [Mr B's] left foot (unstageable).

Review of documentation

The hospital admission documentation dated 29th June 2020 refers to pressure injuries on his heel and back. The facility notes refer to protector pads being applied to his left heel and left big toe on 22 June 2020. However, the facility documentation refers to "protector pads" being applied to his heels and left toe on 22 May 2020. On 15 June 2020, the progress Notes state that "Noticed blueish mark in left heel sole area. Nurse emailed". On 19th June, the Progress Notes state that "dark area on left heel seems to be getting worse. I tell him not raising his leg is not helping. He feels someone should be checking it out and putting a dressing on it."

What is the standard of care/accepted practice?

The same standards and accepted practice apply here as they do for the questions about the buttock pressure injury. The fact that a wound of any kind is relatively small does not mean it cannot get infected and that it cannot increase significantly in severity very quickly if not treated appropriately. It is acknowledged that those individuals with spinal injuries or paraplegia are very susceptible to pressure injuries which they may not necessarily be aware of. It is for this reason that those entrusted with their care should pay particular attention to this area of clinical risk. Pressure injuries on the heels are amongst the most common among those that need to spend significant time lying down or remain in one position for long periods of time (3). It would be reasonable to expect close monitoring of these at-risk areas at all times.

If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe?)

The documentation supplied indicates to me that there were some issues or potential red flags concerning this man's left foot several weeks prior to the wound chart being instigated. There was no evidence of a short-term care plan which again would have allowed other factors such as foot position and footwear to be considered and documented. There was documented evidence of what appeared to be preventative interventions ("protector pads") although it wasn't clear to me what these specifically were. Furthermore, this client was regularly assisted with his shower and although not specifically documented it would be reasonable to assume that the skin was visibly checked on these occasions.

Having considered the above using the same rationale as that for the sacral pressure injury, my view is that there has been a moderate departure from expected practice.

How would it be viewed by my peers?

I believe that my peers would agree with my views.

Recommendations for improvements that may help to prevent a similar occurrence in the future.

The recommendations here would be similar to those relating to the sacral pressure injury above.

3. The treatment of [Mr B's] purple bag syndrome. Were there indicators for a different treatment path that could and should have been taken?

Review of documentation and literature.

Purple bag syndrome is a relatively rare phenomenon whereby the urine in a catheter turns a purple colour as a result of a chemical reaction between the urine and the bag or tubing. The urine itself is not purple before it comes into contact with the tubing. The most common cause is prolonged catheterisation alongside a urinary tract infection. The purple discolouration itself is benign but any UTI that is behind it needs to be investigated and appropriately treated (8).

The treatment of asymptomatic bacteriuria is generally not treated with antibiotics as there is usually no discernible benefit when there is bacteria in the urine without symptoms and there is an increased risk of antimicrobial resistance (4).

[Mr B] had a long history of urinary tract infections according to the facility response dated 16/10/2020. Given this and the aforementioned information on purple bag syndrome, the important matter here is whether [Mr B] was being monitored appropriately for signs of infection which would be increased with the long-term use of a catheter. In other words, it is not the purple bag itself that is of specific concern but what it may represent and whether this was appropriately monitored that was my focus here.

A short-term care plan for management of a UTI was commenced on 31/1/2020 and nil purple colour is noted on 7/2/2020. At this time he also appears to have been on antibiotics for treatment of a UTI as the care plan is annotated "Abs taken as prescribed" and an antibiotic prescription is evident in the note provided. A subsequent short term care plan was commenced on 25/9/2020 although this is after the enquiry end date of 31/7/2020. There did not appear to be any other short term care plans relating to a UTI between the aforementioned dates.

The Risk Management Action Plans refer to being aware of catheter changing in colour and becoming purple or blue. Also, "Should [Mr B] get Blue Bag Syndrome, inform his mother ASAP. Call District Nurse."

Clinical observation sheets (BP, pulse, etc) for the period in question appeared largely unremarkable. In this instance I have summarised what I consider to be key events below. It should be noted that in between these dates are numerous documented occasions when the client is noted to be "well", that "obs are normal" and that "the catheter is draining well" and there were "no concerns".

4/5/2020	[Mr B] returned from hospital having had a gall bladder drain inserted. Started 2 weeks isolation which included regular "Covid obs".
9/5/2020	Progress notes. Minimal urine output overnight. Checked again at 11.30, only 75mls. Flushed later and catheter unblocked.

20/5/2020	Clinical notes. The District Nurse came and among other clinical interventions, changed the IDC.
27/5/2020	Progress notes. Looks pale. Obs taken urine output low overnight.
29/5/2020	Progress notes. Room smells of urine. Still looks pale
30/5/2020	Progress notes. No urine in catheter bag, Flushed and urine seems to be flowing freely. Still smells in bedroom.
1/6/2020	Progress notes. Feeling a little down, He suspects UTI. Did obs to check temp. Was normal. Phoned DN re [Mr B's] concerns about blocked bag and temp 37.7°C. Has come down from yesterday 37.8°C (blue catheter bag) No reply from DN. Phoned on call RN. No answer. Left a message for her to call back.
2/6/2020	Progress notes. Purple bag evident. Obs taken after cares. Good normal.
3/6/2020	Progress notes. Didn't eat much. Commented not hungry last couple of days.
4/6/2020	Progress notes. Noted urine was high colour, bloody mucus in tube. From time … Was up catheter draining more freely and mucus flushed through the bag
4/6/2020	Progress notes. Bag still slightly blue
19/6/2020	Progress notes. … Still concerned about blue bag. Thinks he should be on antibiotics.
29/6/2020	Temp 38°C, HR 122, "Feeling a little lethargic. Pain in lower R quadrant comes and goes". Ambulance called and transferred to hospital.
29/6/2020	The ED admission document states that [Mr B] had been unwell for 2 weeks feeling fatigued and lethargic. SPC inserted during admission.

What is the standard of care/accepted practice?

When an individual has a long-term catheter, the expectation would be that this was changed regularly after a specific period of time depending on the type of catheter used. This appears to have occurred, with the District Nurse coming in to carry out the catheter changes. In the event of someone having a history of UTIs and also with Purple Bag Syndrome being identified as part of the Risk Management Plan, that this was appropriately monitored and documented. This becomes particularly important when supporting a clinically complex client such as [Mr B] where any one of several different issues could potentially be the source of complication or infection. As with any issues of concern, the expectation would be that clinical concerns are escalated appropriately.

If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe?)
The risk of UTI was noted on documentation. There was certainly evidence of catheter changes, urine output being monitored, reference to observations being taken, and interventions such as that which resulted in the hospital admission on 29th June 2020. A short-term care plan was started earlier in the year and antibiotics prescribed by the GP to treat a UTI and again after the time period of concern.

However, it was on the 1st June 2020 that the staff member was concerned enough to phone both the DN and the RN on call. It appears that neither were in a position to respond and it is not clear to me what follow up there was after this. [Mr B] improved, but at the time there was a concern, and it would seem there was no follow up. In the days following this there also appeared to be some red flags, particularly around looking pale, being lethargic and the resident themselves stating that they feel they need to be on antibiotics. Furthermore, although the Risk Management Plan stated that the client's mother and the District Nurse should be advised if he developed a blue bag, it was not clear that this had actually happened on the occasions that it was noted.

The issue for me is that [Mr B] was clinically complex with a number of different issues to consider. There is no doubt that clinical issues were being recorded but what wasn't clear was whether there was a clearly defined and consistent plan of action. For example, when would the facility have called the GP with respect to his catheter? If the client says he thinks he should be on antibiotics as was documented, then would it not be reasonable to discuss this with the GP or his mother as Power of Attorney? Having considered all these factors my view is that there has been a moderate departure from accepted practice. Again, this is because there were interventions but there wasn't a clear and cohesive approach that was documented and followed as evident by the events on and around 1st June 2020.

How would it be viewed by my peers?
I believe that my peers would agree with my views.

Recommendations for improvements that may help to prevent a similar occurrence in the future.
The Progress Notes has a summary of the Stop and Watch Early Warning Tool at the bottom of each page (9). This is in my view a useful tool which reminds care staff in particular to highlight changes in an individual's presentation or behaviour that shift. It would be beneficial to remind staff of its purpose and value particularly when supporting clinically complex clients such as [Mr B].

4. The management of [Mr B's] suprapubic catheter. Whether the issues with [Mr B's] catheter were identified within a reasonable time period? Please comment on the reasonableness of the care provided.

Review of documentation

[Mr B] was admitted to hospital on 29 June 2020 and during the course of this admission he had a supra pubic catheter inserted as a booked outpatient appointment which was intended for this procedure was cancelled due to covid. The SPC was inserted on 7 July 2020 and was noted to have been a difficult procedure. On 9 July 2020, he was transferred back to the facility and arrived there at 10.00hrs.

9/7/2020	14.40hrs. Progress notes. Obs taken at 11.00 hrs, recorded on TPR chart. Asked if he had pain, [Mr B] reported nil obs to be done 15.00hrs
9/7/2020	Short Term Care Plan commenced. To monitor for any decline in health on return from hospital in first 24 hrs. Any signs or symptoms of decline. Purulent discharge from SPC site, Abdo pain, Raised temp. Take QID obs, check pain levels.
9/7/2020	17.30hrs OT note in Progress Notes. Short term care plan in place — for QID obs (4 hourly). Call RN on call and client's mother if client deteriorates. Client to receive full assistance with all cares at this time.
9/7/2020	OT note in Progress Notes. 17.15hrs Client's temp is 37.9°C. Staff followed protocol and provided prn paracetamol at 15.30. Phone message left with client's mother. Temp check one hour later. Remains at 37.9°C Client states he feels well and wants to get up for dinner. Discussion written in notes about moving client to main house for closer observation but client reluctant so appears to have stayed in his unit whilst still being monitored.
9/7/2020	21.50. Progress Notes. Temp check at 15.00 hrs 37.9. 2 paracetamol given at 15.25. Temp check at 19.10 (37.2) 2 paracetamol taken at 19.30. Temp check at 21.10 (36.8)
10/7/20	(written as 9/7/2020 in notes but this appears to be a mistake) 6.00hrs. Progress Notes. Settled and slept very well. Temperature checked in the morning (37°C). No concerns.
10/7/2020	08.40 hrs. Clinical Notes SPC output 500mls Looks pale in complexion.
10/7/2020	12.30 Clinical Notes. Received p/c from RN explaining that [Mr B] was saturated right through. Writer rang continence nurse and agreed that hospital transfer was a good idea. Nil output noted in urine bag from 08.30–12.30
10/7//2020	14.00hrs Progress Notes. DN came at 11.20hrs. Wounds attended to by DN staff x2. Ambulance arrived 13.15 hrs

10/7/2020 Admission Document at ED. This morning catheter bag had 500mls in it. Later [Mr B] noticed that his trousers were wet and the bag had not been filling again.

What is the standard of care/accepted practice?

Apart from any potential blockage, a low urine output is a clear sign that further investigation or input is required. Depending on the weight and clinical presentation of the individual concerned, a urine output lower than 25–30mls per hour is generally considered of clinical concern. It would be an expectation that urine output was noted as a matter of course although not necessarily on a fluid balance chart unless there was a particular concern about fluid input or output. However, in my professional opinion, when an individual has had a procedure and the discharge summary explicitly states that "if becomes unwell with fever/abdo pain/purulent discharge from SPC site, then will need an urgent CT abdomen" there would be an expectation that urine output is also monitored closely. In situations such as this the expectation would be that the urine bag is emptied as soon as possible after arrival back at the new location (in this case the facility) so that it was totally clear what the ongoing urine output was after arrival. It was not clear to me over what time period the 500mls of urine mentioned in the notes was recorded from and how much of this was already present in the bag when he returned from hospital.

If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe?)

The facility responded in a reasonable time once the blocked catheter was identified. In my view it was not possible to state whether matters could have been identified earlier because of the lack of documentation with respect to urine output. Given that a short term care plan was commenced to monitor for any decline in health on return from hospital in first 24 hrs, on [Mr B's] transfer from hospital I would consider it an omission that urine output was not considered to be an important part of this monitoring. It appears from the documentation (500mls drained on morning of 10/7/20) it was being recorded, but from a clinical perspective, this is not necessarily the same as actually monitoring urine output not least because the time frame isn't clear. If the bag was emptied on arrival at the facility, then 500mls is a reasonable output, but if say 480mls is already in the catheter bag then clearly the subsequent 20ml output is concerning. This omission is in my view even more significant given that the reason for this observation was specifically because he had an SPC recently inserted. I therefore consider this to have been a moderate departure from accepted practice.

How would it be viewed by my peers?

Although it may be argued that the monitoring of urine output was not mentioned on the discharge summary I believe my peers would agree that any health professional should be utilising critical thinking. In these circumstances the use of critical thinking rather than replicating what has been written on the discharge summary would lead those managing [Mr B] to closely monitor his urine output particularly given his history

in terms of UTIs and blockages. I therefore believe that my peers would agree with my views.

Recommendations for improvements that may help to prevent a similar occurrence in the future.
An important issue here is I feel the absence of critical thinking and consequently education in this area would be useful for all staff as well as revisiting the Stop and Watch tool.

5. The timeliness of [Mr B's] assessment and escalation to a General Practitioner

Review of documentation.
I acknowledge that I have not viewed the specific contract for the service that [Mr B] was under at the time of this complaint. However, I note Bupa's documentation that all clients will be seen by their GP at least 6 monthly and that, "each client's doctor together with the nurse for each area is responsible for maintaining the health of our clients".

It would appear from review of the available documentation that [Mr B] was not seen by his GP over the course of the period in question. However, the General Practice was phoned on 21 May 2020 to book an x-ray and the District Nursing service was also closely involved on numerous occasions.

What is the standard of care/accepted practice?
The GP is an important part of the healthcare provision for any client living in a community setting such as was the case with [Mr B]. The expectation would be that the RN contacted the GP either directly or through the Practice Nurse if they had any clinical concerns. In terms of clinically complex clients such as [Mr B], it would be accepted practice that the GP would be closely involved with providing necessary support to both the individual and the facility.

If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe?)
In my professional opinion, I believe that there could have been more communication between the General Practice and the facility, and I have addressed this in the section on policies and procedures. There were a number of times when the District Nurses were contacted and this was entirely appropriate. However, as the primary health provider there were also opportunities for the GP to be involved more closely. In my view this is in part an issue of process which I have commented on in the section on policies. However, there were also opportunities for appropriate escalation, the events relating to the UTI at the beginning of June 2020 being a case in point as well as the ongoing cough. Like all issues considered, the fact that the concern may not have deteriorated further at the time does not in itself mean that the GP should not have been made aware. In view of this, I consider there to have been a moderate departure from accepted practice.

How would it be viewed by my peers?
I believe that my peers would agree with this view.

Recommendations for improvements that may help to prevent a similar occurrence in the future.
See section on policies and procedures involving closer GP involvement with care.

6. Any other matters in this case that you consider warrant comment

While reading through the notes I was aware of the ongoing cough and discomfort relating to the position of the biliary drain. There appeared to be numerous references to the cough and also discomfort at the drain site, but follow up with the GP with respect to an Xray appeared to require prompting from the client's mother. This would suggest to me a lack of critical thinking and awareness of the potential clinical risks relating to a new and persistent cough regardless of whether a direct association with the drain was made.

7. The adequacy of policies/procedures

What is the standard of care/accepted practice?
Any residential care facility must have appropriate policies and procedures as required by the MoH Service Standards (1). They need to be both relevant to the service sector in question, up to date and readily available for staff to access so that they become a useful source of information and support good practice.

If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be, (mild, moderate or severe?)
I have reviewed the documentation supplied by Bupa, including the information on Client Review and File Review ([labelled] appendix 1), Protocols ([labelled] appendix 6) and Monthly Health Clinic details ([labelled] appendix 19). The policies and procedures appeared reasonable and reasonably detailed and thorough. For any of these policies and procedures to be effective staff must of course be aware of them and utilize them in their daily practice.

There appeared to be a strong focus on the rehabilitation and goals aspect of care, but limited focus on more clinical aspects of care. It was not clear to me what people were present at the Monthly Health Clinic and what its purpose was. In many respects it appeared to be a monthly summary of what has occurred over the last 4 weeks when it could have been an opportunity to look at ongoing issues and how they might be better addressed. It appears that there was no GP involvement and for someone as clinically complex as this client this may have been useful in terms of clinical oversite and more of an interdisciplinary perspective. It wasn't clear on the summaries when the client had last seen the GP and although I acknowledge that it would probably be unrealistic to have the GP there, GP input or an acknowledgement that they had an awareness of this summary would be useful otherwise there are no prompts for the GP to get involved or ask questions.

I therefore consider that there has been a moderate departure from accepted practice when it comes to policies involving the support of complex clients such as was the case here.

How would it be viewed by my peers?
I believe that my peers would agree with my views.

Recommendations for improvements that may help to prevent a similar occurrence in the future
Greater involvement with the GP would be useful when supporting these complex clients so that the monthly clinical reviews become tools and prompts for the GP that may result in a follow up visit.

8. Summary

When describing the level of departure from accepted practice I have specifically used the HDC terms mild, moderate and severe as laid out in their guidelines. When considering the most appropriate term to use for each question and for the purposes of consistency, I have viewed a severe departure as being one where there has been little or no appropriate intervention or action. Although a moderate departure from accepted practice does not involve these failings, the use of the word moderate does not imply that I consider any failings in care insignificant.

References

1. Ministry of Health 2008, Health and Disability Services (Core) Standards NZS 8134.1:2008, Wellington, MOH
2. Accident Compensation Corporation. 2017. Guiding principles for pressure injury prevention and management in New Zealand. URL: https://www.acc.co.nz/assets/provider/pressure-injury-prevention-acc7758.pdf Accessed 16/5/2022.
3. New Zealand Wound Care Society. 2012. Pan Pacific clinical practice guideline for the prevention and management of pressure injury. URL: https://www.nzwcs.org.nz/images/publications/2012_AWMA_Pan_Pacific_Abridged_Guideline.pdf Accessed 16/5/2022
4. Health Quality and Safety Commission, Frailty Care Guides. 2019. Skin Wounds. https://www.hqsc.govt.nz/assets/Our-work/Improved-service-delivery/Aged-residential-care/Publications-resources/Skin_wounds.pdf Accessed on 16/5/2022 Accessed 16/5/22
5. ACC. Pressure injury in spinal cord injury consensus statement. https://www.acc.co.nz/assets/provider/acc8305-pi-sci-consensus-statement.pdf Accessed 16/5/22
6. HQSC, 2022, https://www.hqsc.govt.nz/our-work/system-safety/reducing-harm/pressure-injury-prevention/measuring-and-reporting-pressure-injuries/ Accessed 16/5/2022

7. Wallis, L, 2010, Some Pressure Ulcers Are Unavoidable, American Journal of Nursing: Volume 110, Issue 9 p16.
8. Pandey et al 2018, Purple urinary bag syndrome: what every primary healthcare provider should know. BMJ online, http://dx.doi.org/10.1136/bc-2018-226395
9. Stop and Watch Early Warning Tool. INTERACT. https://www.in.gov/health/files/INTERACT_Stop_and_Watch_Early_Warning_Tool.pdf Accessed 18/5/2022

Appendix — Timeline of significant events

14 April 2020	Sacral wound first documented as identified by facility staff. States "broke down in hospital"
1 May 2020	"Currently in hospital" written in facility notes
4 May 2020	Discharged from Hospital and returned to facility with biliary drain
5 May 2020	Cavilon cream applied to buttocks and noted to have deteriorated on return from hospital.
6 May 2020	Buttock PI appears to be healing according to notes
9 May 2020	Poor urine output. Catheter flushed and unblocked.
11 May 2020	Catheter flushed by resident
19 May 2020	Podiatry visit. Left forefoot more swollen than usual. Challenging to trim some digits on L foot.
20 May 2020	DN came to visit PI and wound site.
20 May 2020	Temp 38.4°C. After Panadol temp was 37.5°C. Frequent mention of sharp pain when breathing in here and also previously mentioned since return from hospital.
21 May 2020	Ongoing pain when breathing and slight cough. RN phoned and advised Panadol and to sit more upright. Ongoing discomfort. Phoned ambulance who advised that he organize an x-ray through GP. Mother concerned that tube had moved. Any laboured breathing to be referred to ED. Medical practice phoned to arrange Xray.
22 May 2020	"Protector pads" applied to left heel and toe.
25 May 2020	PI dressing continues. Declines to stay on side to relieve pressure though.
26 May 2020	Biliary drain continues to drain and has been regularly recorded since return from hospital at beginning of month

27 May 2020	Looks pale. Obs taken but not recorded in notes. Urine output low overnight. Biliary drain not draining and kinked.
29 May 2020	In evening noted that room smells of urine. No obvious leakage. Still looks pale. Catheter bag full. Gall bladder bag empty.
1 June 2020	Could not lay on his side as sore at drain site. Blue urine bag noted. Resident feels that he may have a UTI. Temp 37.8°C. Phoned DN for advice re purple bag and also facility RN.
2 June 2020	Purple bag evident
3 June 2020	RN attended to buttock wounds and applied a sacral dressing. RN arranged for DN to visit in afternoon.
3 June 2020	Not eating and has not been eating much over last few days. No output from biliary drain.
4 June 2020	Bag still slightly blue.
5 June 2020	Hospital OP appointment
9 June 2020	Progress notes. Minimal urine output overnight. Checked again at 11.30, only 75mls. Flushed later and catheter unblocked.
9 June 2020	Clinical notes. The District Nurse came and changed IDC.
18 June 2020	Progress Notes "dressing has come off. No more dressings so we have just put a pad on buttocks".
19 June 2020	DN changed dressing plan on sacrum.
22 June 2020	Wound care plan for left big toe started and for left heel
22 June 2020	Facility clinical notes. "Alleyvn Life for protecting heel x 1. Non broken pressure injury. Alleyvn for protection toe (L)"
29 June 2020	Temp 38°C, HR 122, "Feeling a little lethargic. Pain in lower R quadrant comes and goes". Ambulance called and transferred to hospital.
29 June 2020	Admitted to hospital with infection likely secondary to sacral PI. SPC inserted as an inpatient as OP appointment delayed because of Covid.
9 July 2020	Discharged from hospital back to facility.
10 July 2020	Admitted to hospital with blocked SPC and infection requiring admission and IV antibiotic treatment.
22 July 2020	Discharged from hospital back to facility. Facility completes a short term care plan for management of PI on buttocks.

Richard Scrase
Registered Nurse
25 May 2022'