The Ultimate Care Group Limited
(trading as Ultimate Care Rhapsody)

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00340)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This case concerns the care provided to an elderly woman who was discharged from a lengthy stay in hospital to rest-home-level care at Ultimate Care Rhapsody, which is operated by The Ultimate Care Group Limited (UCG). Staff at Rhapsody were concerned that the woman required a higher level of care than rest-home level, owing to her medical problems and assistance requirements, but did not take steps to initiate a change in her care level. There were also issues with the woman's initial care planning at the time of admission to Rhapsody.

2. The woman's condition deteriorated while she was at Rhapsody and, after seven days in the rest home, she was transferred back to hospital, where she was diagnosed with sepsis secondary to cellulitis. Sadly, the woman died the following day.

Findings

3. The Deputy Commissioner considered that there were serious issues with the planning of the woman's care at Rhapsody, and attributed these to UCG as the service provider. The Deputy Commissioner found that the woman did not have a clear initial care plan to guide nursing staff in providing coordinated care in light of her multiple medical problems; no steps were taken to have the woman reassessed for a higher level of care; and Rhapsody staff were not proactive in obtaining the discharge summary or interRAI assessment from the DHB. The Deputy Commissioner found UCG in breach of Right 4(1) of the Code.

4. The Deputy Commissioner was critical that on discharge from the district health board (DHB), the woman was assessed as requiring rest-home-level, rather than hospital-level care.

Recommendations

5. The Deputy Commissioner recommended that UCG arrange further education for its staff on initial assessment and care planning, decision-making and early intervention for deteriorating patients, and management of cellulitis. She recommended that UCG use a standard form to document handovers from the DHB, and take steps to ensure that its staff are clear on the process required for timely reassessment of a resident if a higher level of care is needed. She also recommended that UCG review its policies and procedures around managing a resident who requires a higher level of care, and provide an apology to the woman's family.

6. The Deputy Commissioner recommended that the DHB prepare a case study to share with staff involved in discharge planning, for educational purposes.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother, Mrs A, by Ultimate Care Rhapsody. The following issue was identified for investigation:

- *Whether The Ultimate Care Group Limited (trading as Ultimate Care Rhapsody) provided Mrs A with an appropriate standard of care between 9 Month3[1] and 16 Month3 2019 (inclusive).*

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

9. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Ultimate Care Rhapsody	Provider

Also mentioned in this report:

RN C	Registered nurse
RN D	Registered nurse
Dr E	General practitioner

10. Further information was received from the ambulance service and the district health board.

11. Independent expert advice was obtained from Registered Nurse (RN) Rachel Parmee (**Appendix A**).

Information gathered during investigation

Background

12. Mrs A (aged in her eighties) lived at home with her husband, who supported her with activities of daily living. On 23 Month1, a DHB care manager undertook an interRAI assessment[2] for Mrs A. The reason for the assessment was that Mrs A's health and mobility had deteriorated over recent months and she needed more support. The assessment concluded that Mrs A met the criteria for rest-home-level care, and the assessment was deemed valid for a six-month period.

[1] Relevant months are referred to as Months 1-3 to protect privacy.
[2] A resident assessment instrument — a standardised clinical assessment instrument for evaluation of the needs, strengths, and preferences of consumers.

Admission to the public hospital

13. Mrs A was admitted to the public hospital on 26 Month1 following a fall at home. She was found to have acute coronary syndrome, cellulitis, urinary retention, constipation, cardio/renal syndrome, hypotension, and elevated potassium levels and low sodium. While initially Mrs A's family were informed that she was likely to pass away from her presenting illnesses, her condition began to improve from 30 Month1, and she was admitted to the Older People's Health and Rehabilitation Ward.

14. On 3 Month3, a meeting was held to discuss Mrs A's discharge. This was attended by Mrs A, her family members, and the multidisciplinary team, including a consultant geriatrician, a house surgeon, the care manager (who had undertaken the interRAI assessment), a social worker, an occupational therapist, and a physiotherapist. The team's recommendation was for Mrs A to be discharged into rest-home care. Despite Mrs A's wish to go home, the DHB told HDC that Mrs A reluctantly agreed with her family and the team that she would be better off going to a rest home.

15. The DHB told HDC that the team were cognisant of the fragility of Mrs A's condition, and acknowledged that she might require reassessment of the level of her care in the future; however, it was the view of the multidisciplinary team that at discharge she required rest-home-level care. The DHB did not undertake a further interRAI assessment because the current assessment (dated 23 Month1) was deemed to be valid for a six-month period.

16. After seven weeks in hospital, on 9 Month3 Mrs A was discharged to rest-home care. The seven-page discharge summary from the DHB, dated 9 Month3, included the following information:

a) Mrs A required assistance in and out of bed, and while mobilising, from one person. She also required the use of a bed lever.

b) She had two falls while in hospital.

c) She had a skin tear on her right forearm, and a lower leg ulcer that required daily dressings.

d) Her medical diagnoses while in hospital included cellulitis, sepsis, hypokalaemia, and myocardial infarction.

e) She was taking warfarin (a blood thinner) and there was a request for her to have her INR[3] checked in three days' time and her dose adjusted accordingly.

f) She was to be seen by a GP within a week to review her fluid status.

g) She was incontinent.

h) She had some impairment with her recall.

[3] The international normalised ratio (INR) measures the time it takes for a person's blood to clot. INR testing is well established as an integral part of warfarin (blood-thinning) treatment. INR has a critical role in maintaining the warfarin response within a therapeutic range, to provide the benefits of anticoagulation, while avoiding the risks of haemorrhage.

Admission to Ultimate Care Rhapsody

17. Mrs A was admitted to rest-home care at Ultimate Care Rhapsody (Rhapsody) on 9 Month3. Rhapsody provides rest-home and hospital-level care for up to 70 residents, and the service is operated by the Ultimate Care Group (UCG).

18. Rhapsody was provided with a nursing transfer form from the DHB. The nursing transfer form noted that Mrs A required daily weighs and management of fluid overload, that she required physiotherapist assessment/input, and that she had cellulitis on her left lower leg secondary to a chronic ulcer, which required daily dressing. The form also stated that Mrs A was doubly incontinent, required full assistance with all cares, her skin was broken in places, and that she had had a fall on 4 Month3.

19. UCG stated that it understands that Mrs A's discharge from the DHB was communicated to the Rhapsody Team Leader, RN D, via telephone, and notes were written on a scrap of paper, which was later discarded, rather than on its enquiry form.

20. The DHB is confident that the following process would have been followed when transferring Mrs A's care to Rhapsody: online discharge summary completed, nursing transfer form completed, phone call to rest home with verbal handover to registered nurse, paperwork given to patient/family to give to rest home on arrival, and prescriptions faxed to the rest home's pharmacy.

21. UCG told HDC that the discharge summary from the DHB (detailed above) did not arrive until 15 Month3, six days into Mrs A's admission. There is no evidence that UCG attempted to obtain this from the DHB. UCG also said that it did not have a copy of Mrs A's interRAI assessment. UCG stated: "If there was a community InterRAI assessment completed prior to her admission, Rhapsody would not have been allowed to access this." However, it also stated:

> "[O]ur expectation is that we would receive a copy of the community InterRAI assessment that informed the NASC (needs assessment services) decision to place Mrs A at rest home level care."

22. UCG told HDC that each resident's health and personal care needs are assessed on their admission in order to establish an initial care plan, which covers a period of up to 21 days. UCG provided a copy of the initial care plan (dated 9 Month3), as well as copies of additional assessments that were carried out on Mrs A's admission, including a pressure area risk assessment, falls assessment, oral and nutritional profile, and continence assessments.

23. UCG told HDC that there is a lack of evidence to show that sufficient information was provided in the initial care plan, for example, that Mrs A was being treated with warfarin. UCG stated: "[T]he care plan lacked to advise staff [Mrs A] could be susceptible to bruising and prolonged bleeding."

24. In the initial care plan, under the heading "skin soft tissue wound integrity assessment", only the left lower leg ulcer is documented as a current wound, with the comment

"dressings". There is no mention of a skin tear on Mrs A's arm, her general skin condition, or cellulitis.

25. The initial care plan refers to Mrs A being on fluid restriction of 1.5L per day, but not that she required daily weighing.

26. UCG told HDC that Mrs A was not deemed to have diminished mental capacity prior to or during her admission, and that she did not have an activated Enduring Power of Attorney (EPA). While the DHB nursing transfer form recorded that Mrs A's next of kin was her husband, no UCG documents provided to HDC recorded Mrs A's family contact preferences.

Care from 9–16 Month3

27. In the progress notes of 9 Month3 it is documented that Mrs A required two-person assistance for mobilising, as she was very unsteady on her feet and seemed confused. The notes state that Mrs A was asking for pain relief as her right arm was sore (and that she was given 1g paracetamol), that she had an ulcer on her left lower leg and a "reddened raw [right] groin", and that otherwise her skin appeared intact.

28. On 10 Month3, a short-term wound care plan was commenced for Mrs A's left lower leg ulcer. The plan referred to the wound assessment and treatment form that provided dressing guidance, but did not refer to Mrs A's cellulitis.

29. At 11.40am on 10 Month3, Mrs A was seen by a gerontology nurse specialist who reviewed Mrs A's lower leg ulcer. The nurse documented an updated dressing plan in the allied health notes, along with a request to moisturise Mrs A twice daily and encourage mobilising.

30. The medication chart records that Mrs A's first dose of warfarin (at Rhapsody) was given at 9pm on 10 Month3.

31. On the night shift of 10 Month3, RN C documented that Mrs A was given paracetamol for pain in her right elbow, and that the area was swollen and hot to touch. RN C recorded that during a discussion with Mrs A's family, they advised that Mrs A had had a fall while in hospital but that no injuries had been noted.

32. The progress notes of 11 Month3 include a comment that Mrs A had been seen by the wound specialist nurse the previous day, and that the updated wound management plan was to be commenced on 13 Month3 when the dressing was next due to be changed.

33. At 7.15pm on 11 Month3, RN C completed an incident report for a 2.5cm x 2.5cm skin tear on Mrs A's left lower arm. The report states: "[W]hile transferring from the walker to the commode noticed a skin tear on the left lower arm." The report notes that Mrs A's husband was notified of the skin tear at 7.40pm. The documented plan was to moisturise Mrs A's skin regularly as it was dry and fragile. This skin tear was listed on the wound and skin assessment and treatment form. The resident infection summary chart lists a skin tear

category 1b[4] dated 11 Month3, but the location is not listed. Mrs A's family stated that this is the only time Mr A was notified of an incident.

34. The progress notes of 12 Month3 written by RN D refer to a dressing being applied to Mrs A's right elbow.

35. At 10.30am on 12 Month3, a caregiver completed an incident report for a further skin tear to Mrs A's left arm. This stated: "Putting [Mrs A] onto commode. She hit her arm on the arm of the commode chair." The report was reviewed by RN D, who documented the corrective action taken as: "[D]iscussed about transferring slowly to prevent knocking her arms which has been causing skin tears." The report notes that Mrs A's husband was informed of the incident. The report also states: "[N]ew resident admitted @ [rest-home-level care;] however, requiring reassessment for higher level. Discussed." It is not clear with whom the report was discussed. The wound and skin assessment and treatment form on this date records a skin tear on Mrs A's right elbow.

36. On 13 Month3, the progress notes written by a caregiver at 1.30pm record that Mrs A's knee gave way when she was getting off the commode, and that she was lowered to the floor and a nurse and other caregivers helped to put her back onto her bed. Mrs A's family are concerned that only one caregiver was assisting Mrs A onto the commode. Mrs A's family told HDC that Mr A was present at the time of this incident. In response to the "information gathered", Mrs A's family also commented that it would have been nearly impossible for one person to lower Mrs A safely, as she weighed nearly 100kg.

37. The progress notes also state that at 2.20pm, the emergency bell was rung and Mrs A was found lying on her side on the floor, with a small amount of bleeding on her left upper arm. The progress notes record that Mrs A's husband was present at the time; however, Mrs A's family advised HDC that no family members were informed of the incident.

38. At 7.56pm on 13 Month3, a caregiver completed an incident report for a skin tear on Mrs A's right knee. The report states: "[A]ssisting [Mrs A] with her cares this shift (pm) notice a skin tear on [right] knee. Informed RN." The corrective action section of the report states: "[M]oisturise the skin regularly and provided arm protector to wear to reduce skin tear." A note apparently added to the incident report on 14 Month3 states: "Poor skin integrity — bruising ++ ? spontaneous or post cellulitis." The resident infection summary dated 13 Month3 notes a category 1b skin tear on the right knee, and this is also documented in the wound and skin assessment and treatment form. The incident report states that Mrs A's husband was informed of the incident, but Mrs A's family told HDC that no family members were advised of this incident.

39. At 2.20pm on 15 Month3, Mrs A was seen by a general practitioner (GP), Dr E. On examination, Dr E found that Mrs A had a "cellulitic looking left forearm". He commented that the skin had broken down, and that generally it looked infected. He prescribed antibiotics and an additional daily dose of frusemide to assist in reducing Mrs A's fluid

[4] A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky, or darkened.

accumulation. Dr E planned to review Mrs A again in a week's time. He also commented: "Has been deemed Rest Home level care. This seems inappropriate — staff feel she is way beyond this, and this certainly appears the case today." In response to the "information gathered", Mrs A's family expressed concern at the delay in Mrs A being seen by the GP following her admission, and said that her medical history was not available as no notes had been requested from her previous GP.

40. UCG told HDC that Mrs A's antibiotics were given on 16 Month3 at 9am, and again between 12 and 1pm.

41. On 16 Month3, it was noted by RN C that Mrs A's left lower arm wound had broken down further and the cellulitis had increased on both her legs and hand. RN C recorded that in the afternoon, Mrs A was having trouble swallowing medications and eating. Her vital signs were assessed as: temperature 36.3°C, pulse 86bpm, and blood pressure 110/70mmHg. RN C contacted Dr E's surgery and was awaiting a reply when Mrs A's family requested that she be taken to hospital by ambulance. In response to the "information gathered", Mrs A's family said that the call to Dr E's surgery was placed after they had requested the ambulance transfer.

42. Accordingly, Mrs A was transferred to the public hospital by ambulance and admitted with sepsis secondary to cellulitis in her left arm. Sadly, Mrs A died in hospital the following day.

43. An Emergency Medicine specialist took care of Mrs A at the public hospital. The specialist told HDC that Mrs A had suffered extensive skin tears to nearly the full length of her left forearm. The specialist stated: "[Mrs A] was on Warfarin at the time and this, in addition to her overall frail condition and age, undoubtedly contributed to the extensiveness of the wound."

Further information

44. Throughout the documentation of Mrs A's wound care, there is no evidence that cellulitis was documented regularly with photographs or mapping of the margins of the infection.

45. UCG stated:

> "We believe that [Mrs A's] general condition upon discharge from [the DHB] was not reflected as well as it should have been, in that her status was not correctly assessed as described at Rest Home level. In our opinion [Mrs A] should have been hospital level, supported by the General Practitioner's comments on admission.
>
> [Mrs A's] health deteriorated very rapidly from the time of admission, it was clear this resident was indeed extremely unwell and not recovering from her admission of Sepsis during her stay on the Medical Ward at [the DHB]."

46. In their response to the "information gathered", Mrs A's family stated that they "absolutely dispute" UCG's claim that Mrs A's health deteriorated very rapidly from the time of admission. They stated: "She was looking the best she had ever been in months

and was so well that she attended the concert at UCG [two days after admission] and thoroughly enjoyed herself."

47. UCG explained to HDC its usual process when it identifies that a resident requires reassessment for a higher level of care. It said that it is crucial that caregivers' knowledge is included in any assessments, so caregivers complete an interRAI form that is designed for caregivers and diversional therapists. If it is clear that there has been a significant change since the previous assessment, the information is passed on to the NASC teams to change the level of care required. UCG stated: "In this instance, [Mrs A] was only at the facility for a very short time, therefore the short timeframe meant the caregivers had less opportunity to follow the process."

48. UCG said that following this event, three regional workshops were held, and signs and symptoms of a deteriorating resident were discussed. The presenter of the workshops used Mrs A's situation as an example.

49. UCG told HDC that a new Team Leader has been appointed at Rhapsody, and the Clinical Nurse Manager (who was on maternity leave at the time of these events) has returned to the facility.

50. Mrs A's daughter told HDC:

> "I understand lodging a complaint is not going to bring back our wife, mother, mother-in-law and grandmother but I do hope this complaint will bring some serious changes/training at Rhapsody to avoid another family having to go through this distress."

Internal investigation

51. Initially, Mrs A's family complained directly to UCG. An internal investigation was undertaken, and the following shortfalls were identified:

> "a) Incomplete documentation
>
> b) EPOA has not been notified of all incidents that occurred at the time
>
> c) Inconsistent handover notes from RN and DHB
>
> d) Inappropriate comment made to family regarding removal of ring.[5]"

Responses to provisional opinion

52. UCG, the DHB, and Mrs A's family were given an opportunity to comment on the relevant sections of the provisional opinion. Where appropriate, their comments have been incorporated into the report.

[5] Mrs A's daughter complained that when she asked Rhapsody staff whether they had bolt cutters to remove her mother's rings from her swollen hand on 16 Month3, they suggested that she use scissors.

53. UCG stated:

> "We would hope that … you have taken into account the lack of documentation provided to [UCG] regarding [Mrs A's] discharge plans on the day of admission from the public hospital. We accept in part, that Rhapsody clinical staff could have been more proactive in requesting the full discharge plan and relevant interRAI information. However, it is still our opinion that in good faith we accepted [Mrs A] as a rest home level resident, and in doing so there would have been less registered nursing hours input in the first forty eight hours which contributed to a further delay in requesting the appropriate clinical information in written form."

54. Regarding the decision to discharge Mrs A to rest-home-level care, the DHB stated:

> "The decision was made laterally using a combined approach and process which encompassed the multidisciplinary team, the family and the patient. We do concede however that our communication to the family in regard to [Mrs A's] fragility or avenues of escalation if her condition deteriorated could have been improved."

55. The DHB stated that based on the assessments of Mrs A's requirements for assistance, it could be perceived that she was appropriate for rest-home-level care. However, the DHB acknowledged that "in retrospect due to the severity of fragility, perhaps hospital level of care may have been more appropriate".

56. Regarding the concerns that Mrs A was inappropriately placed at rest-home-level care, the DHB said: "[W]e would normally have anticipated that concerns related to levels of care would be escalated from the rest home to [the DHB] via NASC."

Opinion: The Ultimate Care Group (trading as Ultimate Care Rhapsody) — breach

Introduction

57. UCG had an organisational duty to provide Mrs A services with reasonable care and skill. Multiple nursing and caregiving staff were involved in Mrs A's care from 9 to 16 Month3. Overall, I consider that UCG holds primary responsibility at a systems level for the poor standard of care provided to Mrs A during this period.

58. I acknowledge UCG's concern that Mrs A was discharged from the public hospital to rest-home-level care inappropriately, and I have commented on this issue in my opinion about the care provided by the DHB. Regardless of whether it would have been more appropriate for Mrs A to have been discharged to hospital-level care, there are aspects of Mrs A's assessment and care planning at Rhapsody that fell short of acceptable standards. Further, Rhapsody staff clearly had concerns about Mrs A's care needs, but it appears that no steps were taken to have her reassessed for a higher level of care.

Assessment and care planning

59. Mrs A was discharged from the public hospital to rest-home care at Rhapsody on 9 Month3. Among other things, she had a lower leg ulcer and cellulitis, fluid overload being managed with fluid restriction and daily weighs, a skin tear on her right forearm, and she was taking warfarin.

60. UCG said that the seven-page discharge summary from the DHB did not arrive until 15 Month3. However, Mrs A's care was handed over from the DHB verbally on 9 Month3 (although the notes from this conversation were not recorded on its standard form and were discarded). Rhapsody also received a nursing transfer form that documented that Mrs A had cellulitis, that her skin was broken in places, and that she required daily weighing.

61. An initial care plan was commenced for Mrs A by Rhapsody, and assessments of her pressure area risk, falls risk, oral and nutritional profile, and continence were undertaken. The initial care plan did not state that Mrs A was being treated with warfarin, it did not mention her cellulitis, and it did not mention the skin tear on her right arm or her general skin condition. Further, while the plan refers to Mrs A being on fluid restriction of 1.5L per day, it does not mention that she required daily weighing. Mrs A was given her first dose of warfarin at Rhapsody on 10 Month3, so it appears that Mrs A's prescriptions had been forwarded to the pharmacy on her discharge from the DHB.

62. Regarding documentation of Mrs A's warfarin prescription, my expert advisor, RN Rachel Parmee, stated:

> "There was no indication on the care plan of this. This is important in terms of monitoring her Warfarin levels (INR blood tests) and the need to be aware that patients on Warfarin are susceptible to bruising and prolonged bleeding."

63. RN Parmee also noted that the initial care plan did not document Mrs A's requirement for daily weighing in relation to her fluid restriction.

64. RN Parmee commented that she is satisfied that the initial assessment documents were completed according to the facility's admission policy, and that appropriate assessment and documentation were completed in relation to Mrs A's wounds. However, there is no evidence that the progress of Mrs A's cellulitis was documented, and RN Parmee advised:

> "Where cellulitis is present it is expected that along with the usual wound observations the progress of the cellulitis needs to be regularly documented using photographs and mapping of the margins."

65. Regarding Mrs A's overall assessment and care planning, RN Parmee commented:

> "While progress notes were of reasonable standard in terms of documentation of [Mrs A's] change in health status they need to be supported by … accurate care plans to ensure that care is provided consistently and in line with a clear plan.

> There was, I believe, a severe departure in terms of documentation of assessment and care planning for [Mrs A]. Given [Mrs A's] history of cellulitis, falls and the risk for bruising and bleeding related to Warfarin treatment there was need for a much more coordinated approach to her care including nursing diagnoses and care planning related to the high risk for infection, poor skin integrity, poor circulation and decreasing mobility."

66. I accept RN Parmee's advice. I am particularly concerned at the lack of initial care planning in place relating to Mrs A's warfarin prescription and the potential care issues relating to this. I am also concerned at the lack of assessment and planning regarding management of Mrs A's cellulitis. In my view, the initial care plan should have referred to the need to weigh Mrs A daily, and should have mentioned her right arm skin tear and general skin condition on admission. While I acknowledge that the discharge information from the DHB may not have been available until later in Mrs A's admission, I consider that there was sufficient information in the nursing handover document and medication prescriptions to inform better care planning. It is apparent that Mrs A was a frail elderly woman with a number of significant health issues that required careful responsive management by all staff involved in her care. I am left with the impression that aspects of her care were piecemeal, which placed Mrs A at risk of rapid deterioration.

67. Despite UCG's opinion that Mrs A required a higher level of care than rest-home level, on Mrs A's admission to Rhapsody it remained UCG's responsibility to ensure that nursing staff had access to a clear initial plan in order to provide coordinated care to Mrs A in light of her multiple medical problems. I am critical that this did not occur.

Failure to initiate reassessment for higher level of care

68. UCG believes that Mrs A's assessment as rest-home level on discharge from the DHB was not correct. UCG stated:

> "[Mrs A's] health deteriorated very rapidly from the time of admission, it was clear this resident was indeed extremely unwell and not recovering from her admission [to the public hospital] of Sepsis."

69. On 12 Month3, an incident report relating to a skin tear on Mrs A's left arm included the comment: "[N]ew resident admitted @ [rest-home-level care;] however, requiring reassessment for higher level. [D]iscussed." It is not clear with whom this was discussed, or whether any further action was taken to have Mrs A reassessed.

70. Dr E saw Mrs A on 15 Month3, and his clinical records include the comment: "Has been deemed Rest Home level care. This seems inappropriate — staff feel she is way beyond this, and this certainly appears the case today."

71. UCG explained to HDC that its usual process when it identifies that a resident requires reassessment for a higher level of care is to have caregivers complete an interRAI form, which is then passed on to the NASC. UCG stated: "In this instance, [Mrs A] was only at the

facility for a very short time, therefore the short timeframe meant the caregivers had less opportunity to follow the process."

72. While I accept that Mrs A was at Rhapsody for only a short period before being readmitted to hospital, I consider that as soon as staff recognised that Mrs A required reassessment for a higher level of care on 12 Month3, this should have been initiated promptly. Rhapsody staff clearly had concerns about Mrs A's care needs, but it appears that no steps were taken to have her reassessed for a higher level of care. I would expect that if Rhapsody nursing staff did not agree with the care level stipulated on discharge from hospital, they would contact the DHB to discuss this and make interim arrangements for a suitable level of care, or swiftly commence the interRAI process (which includes the caregiver observation period). In my view, the failure to do this shows a lack of critical thinking and advocacy for Mrs A by Rhapsody staff, and in particular its nursing staff.

Information gathering

73. UCG told HDC that Mrs A's discharge summary from the DHB did not arrive at Rhapsody until 15 Month3, and it did not have a copy of Mrs A's interRAI assessment. UCG stated: "If there was a community InterRAI assessment completed prior to her admission, Rhapsody would not have been allowed to access this." However, UCG also stated:

> "[O]ur expectation is that we would receive a copy of the community InterRAI assessment that informed the NASC (needs assessment services) decision to place [Mrs A] at rest home level care."

74. In my opinion, the discharge summary from Mrs A's seven-week admission to hospital, and the community interRAI assessment, were both important documents for Rhapsody to consider when planning Mrs A's care. In my view, Rhapsody staff should have been more proactive in trying to obtain these documents at the time of Mrs A's admission, and certainly they should have attempted to obtain them once they recognised that Mrs A required reassessment for a higher level of care.

Conclusion

75. Overall, there were serious issues with the planning of Mrs A's care. In my view, these issues are attributable to UCG as the service provider. UCG failed to provide Mrs A with an appropriate standard of care for the following reasons:

a) Mrs A did not have a clear initial care plan to guide nursing staff in providing coordinated care to her in light of her multiple medical problems.

b) Rhapsody staff clearly had concerns about Mrs A's care needs, but it appears that no steps were taken to have her reassessed for a higher level of care, and no arrangement was put in place in the meantime to ensure that she received an appropriate level of care.

c) Rhapsody staff were not proactive in obtaining Mrs A's discharge summary or her interRAI assessment.

76. Accordingly, I find that UCG breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[6]

Communication with family — other comment

77. Mrs A's husband was listed as her next of kin on the nursing transfer form from the DHB, but no UCG documents provided to HDC recorded Mrs A's family contact preferences. The progress notes indicate that often Mr A was present with Mrs A during her time at Rhapsody. UCG told HDC that Mrs A was not deemed to have diminished mental capacity prior to or during her admission, and that she did not have an activated EPA.

78. Three incident reports were completed for three of Mrs A's skin tears (11 Month3 — left arm, 12 Month3 — left arm, and 13 Month3 — right knee), and the progress notes record that Mrs A was found lying on her side on the floor with a small amount of bleeding on her left upper arm on the afternoon of 13 Month3. The three incident reports and the progress notes all refer to Mrs A's husband being informed of the incidents.

79. However, Mrs A's family complained that Mr A was informed of only one incident (the skin tear on Mrs A's left lower arm on 11 Month3), and the internal investigation undertaken by UCG found that the "EPOA ha[d] not been notified of all incidents that occurred at the time".

80. I accept that Mrs A did not have an activated EPA. However, her husband was clearly very involved in her care, having been her main support at home before she was admitted to hospital, and having stayed with her during much of her time at Rhapsody. While I am unable to make a finding as to exactly which incidents Mr A was informed of, I note that there are discrepancies between the incident reports, progress notes, and the family's account of events, and I also note UCG's finding that Mr A was not advised about all incidents. I consider that the communication with Mrs A's family, particularly Mr A, about these incidents, could have been managed better by Rhapsody staff, and I note that initial recording of Mrs A's family contact preferences would have assisted to do this. I would be concerned if the incident reports incorrectly stated that Mr A had been informed of these incidents, if he had not been.

Opinion: District Health Board — adverse comment

Decision to discharge to rest-home-level care

81. Mrs A was an inpatient at the public hospital for seven weeks. On 3 Month3, a multidisciplinary team meeting was held to discuss her discharge. The team's recommendation was for Mrs A to be discharged into rest-home care. The DHB told HDC that despite Mrs A's wish to go home, Mrs A reluctantly agreed with her family and the team that she would be better off going to a rest home.

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

82. The DHB told HDC that the team were cognisant of the fragility of Mrs A's condition, and acknowledged that she might require reassessment of the level of her care in future. The DHB did not undertake a further interRAI assessment because the current assessment, stating that she met the criteria for rest-home-level care (dated 23 Month1) was deemed to be valid for a six-month period.

83. My expert advisor, RN Rachel Parmee, considers that there was a severe departure in terms of the decision made to move Mrs A into rest-home-level care. RN Parmee stated: "[Mrs A] clearly had multiple medical problems along with decreased mobility, incontinence and ongoing major issues with skin integrity."

84. RN Parmee advised that her assertion that Mrs A was placed inappropriately is based upon the following: Mrs A required one-person assistance and a bed lever on discharge from hospital, and a bed lever would be available on beds provided at hospital-level rather than rest-home-level care; she was on 24-hour fluid restriction, and this indicated a need for close monitoring by a registered nurse, and rest-home-level facilities are not required to provide 24/7 registered nurse presence; Mrs A was noted to be doubly incontinent, and it is accepted practice that a person with double incontinence is cared for in an environment where there is a registered nurse 24/7; and Mrs A had two falls and other significant medical events (cellulitis, sepsis, and myocardial infarction) while she was in hospital. RN Parmee stated:

> "The combination of these factors would, I believe, point to the need for placement at Hospital level care. The almost immediate recurrence of [Mrs A's] cellulitis and retention of fluid would indicate that she was not well enough on discharge from the public hospital to be placed in Rest [home] Level care."

85. I accept RN Parmee's advice about the issues Mrs A faced at the time of her discharge, and that these indicated that hospital-level care was more appropriate than rest-home-level care for Mrs A. In hindsight, it is clear that hospital-level care would have been a better environment for Mrs A on discharge from the public hospital.

86. However, I acknowledge the amount of planning that went into Mrs A's discharge, and the number of staff from different specialties (nursing, medical, occupational therapy, social work, and physiotherapy) involved in the decision-making. I also appreciate that Mrs A's family were closely involved in the discharge planning, and that Mrs A's wish was to go home when she left the hospital. Further, the most recent interRAI assessment, which had been undertaken three days before Mrs A went into hospital, deemed Mrs A to meet the criteria for rest-home-level care.

87. In these circumstances, I can understand why the decision was made to discharge Mrs A to a rest-home environment, rather than to hospital-level care. However, I share RN Parmee's concerns that this was not the most appropriate placement for Mrs A. I note that the DHB acknowledges in retrospect that hospital-level care may have been more appropriate for Mrs A.

Recommendations

88. I recommend that UCG provide a written apology to the family of Mrs A for the failings identified in this report. The apology should be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

89. I recommend that within three months of the date of this report, UCG:

a) Schedule an education session for Rhapsody nursing staff on initial assessments and care planning, and the importance of including key clinical information in initial care plan documentation.

b) Take steps to ensure that all Rhapsody staff are clear on the process required for the timely reassessment of a resident who requires a higher level of care than is being received currently.

c) Review its policies and procedures to include an interim arrangement for the safe management of a resident identified as requiring a higher level of care until the reassessment/transfer to a higher level of care has occurred.

d) Schedule a further education session for Rhapsody nursing staff on decision-making and early intervention for deteriorating patients.

e) Schedule an education session for Rhapsody nursing staff on management of cellulitis.

f) Take steps to ensure that Rhapsody nursing staff are easily able to access and use a standard form document to take notes of verbal handovers from the District Health Board, and keep these notes on the patient record to inform initial care planning.

g) Report back to HDC on the implementation of the above recommendations.

90. I recommend that the DHB's Older People's Health and Rehabilitation Service prepare an anonymised case study (using Mrs A's case and the findings of this report as a basis) to share with all staff who are involved in discharge planning, for educational purposes. Confirmation that this has been done should be provided to HDC within three months of the date of this report.

Follow-up actions

91. A copy of this report will be sent to the DHB.

92. A copy of this report with details identifying the parties removed, except The Ultimate Care Group Limited (trading as Ultimate Care Rhapsody) and the expert who advised on this case, will be sent to HealthCERT and the Health Quality & Safety Commission, and placed on the HDC website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"Thank you for the request to provide clinical advice regarding the complaint from [Ms B] in relation to the care of her late mother [Mrs A] at Ultimate Care Rhapsody during her residence there from 9th [Month3] to 16th [Month3]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

1. I registered as a nurse in 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is co-ordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

2. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] at Ultimate Care Rhapsody was reasonable in the circumstances and why.

   With particular comment on:

   1. The adequacy of the overall care provided to [Mrs A];
   2. The monitoring of [Mrs A's] cellulitis and various skin tears and whether this was in line with current nursing practice;
   3. Any other matters that I consider warrant comment.

   For each question I am asked to advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/ severe.

c. How would it be viewed by my peers?

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

3. In preparing this report I have reviewed the documentation on file:

1. Letter of complaint dated […]

2. Ultimate Care Group's response dated [2019] including the following clinical records:

- Care Plan Policy at time of admission
- Admission guidelines
- Evidence of steps taken since initial complaint
- Resuscitation status
- Initial nursing assessment
- Short term entry notification (NASC)
- Medication signing sheets
- GP medical assessment
- Prescriptions
- Incident and accident forms
- Progress notes
- Allied Health notes
- Resident Review and Risk assessment
- Weight loss chart
- Infection summary
- List of staff

4. Background

[Ms B] is concerned about the care that her late mother, [Mrs A], received from Ultimate Care Rhapsody during her residence there from 9 [Month3] until 16 [Month3].

On 9th [Month3], [Mrs A] moved into Ultimate Care Rhapsody after being discharged from the public hospital, where she had been admitted for a period of 7 weeks whilst receiving treatment for left leg cellulitis, sepsis and hypokalaemia. Her discharge summary, dated 1 [Month3] noted a left lower leg ulcer and a skin tear on her right forearm. Her initial assessment at Ultimate Care Rhapsody recorded her pulse at 68 (bpm), weight at 77.3(kg), blood pressure 115/60 and temperature 35.6 degrees Celsius.

On 11 [Month3], [RN C] noticed a skin tear on [Mrs A's] lower left arm, and a plan was commenced to moisturise [Mrs A] regularly as her skin was very dry and fragile, and to transfer her slowly to prevent knocking her arms.

On 13th [Month3], [Mrs A] sustained an injury to her left arm and a small skin tear on her right knee following a fall. [Dr E], General Practitioner, attended to her on 15 [Month3] and prescribed a higher dosage of furosemide as she appeared to be retaining fluid and antibiotics for a skin infection. Later that day, nurses changing [Mrs A's] dressing reported fluid accumulation under the skin of her left hand, and that it appeared to be infected. [Dr E] advised her to continue with the antibiotics.

On 16th [Month3], it was noted by nursing staff that her left lower arm wound had broken down further and the cellulitis had increased on both her legs and hand. [Mrs A's] condition began to deteriorate throughout the day. Upon assessment of her vitals, her temperature was recorded at 36.3 degrees Celsius, her pulse at 86 bpm and blood pressure 135/70. She was struggling to eat and swallow. This prompted [RN C] to consult [Dr E] for his advice.

[Mrs A] was later admitted to the public hospital by ambulance, at the request of her family, where she later passed away on 17th [Month3].

Review of Documents

5. The adequacy of the overall care provided to [Mrs A]:

Before commenting on the adequacy of care provided to [Mrs A] at Ultimate Care Rhapsody I would like to comment on the appropriateness of her placement in Rest Home level care. Both the GP (in his notes of 15th [Month3]) and [UCG] (letter dated 15th April 2019) question the appropriateness of [Mrs A's] placement in Rest Home level care.

Information provided to Ultimate Care Rhapsody by staff from [the public hospital] indicates the following

- Mobility: the physiotherapist stated that [Mrs A] required assistance of one person and the use of a bed lever
- Skin: The discharge summary dated 1 [Month3] notes that [Mrs A] had a skin tear on her right forearm sustained after one of 2 falls and an ulcer on her left lower leg
- Medical events while in the public hospital for 7 weeks were noted as cellulitis, sepsis, hypokalaemia and myocardial infarction
- Treatments included medication with Warfarin and a 24 hour fluid restriction
- Continence. It was noted that [Mrs A] experienced bowel and bladder incontinence.
- Cognition. [Mrs A] was noted to be mildly confused

From my own experience working at both Rest Home and Hospital level aged care and in consultation with a colleague who until recently was a Needs Assessor I agree that [Mrs A] was inappropriately placed.

In order to be able to comment further, I requested a copy of the InterRAI assessment that informed the NASC decision to place [Mrs A] in Rest Home level care. I am informed that no InterRAI assessment for [Mrs A] was held by [the public hospital] and Ultimate Care Rhapsody had not received one from the Needs Assessors during the time that [Mrs A] was resident there. The ARRC (Age Related Residential Care) agreement states in the section Individual Report and Care services that:

> D16.1. We will ensure that each potential Resident who may be admitted to your Facility (either directly from the community or via in-patient care) has been assessed using the interRAI home care assessment tool in the 6 months before the date on which it is intended that the potential Resident will be admitted, unless there are exceptional circumstances. (Age Related Residential Care Agreement (2019) p51)

Such an assessment would be used to inform the decision about placement to a facility which can provide the appropriate level of care.

My assertion that [Mrs A] was inappropriately placed is based upon:

- **Mobility**. The physiotherapist handover stated that [Mrs A] required one person assistance and a bed lever. A bed lever would be available on beds provided at Hospital level rather than Rest Home level. On the first day of her admission the progress notes state that [Mrs A] required two people to assist her with standing and transferring. Her mobility decreased over the next few days to the point where she required the use of a hoist on the 16th of [Month3]. The rapid deterioration in her mobility and the fact that she required two people to assist her on the day of admission suggests that her mobility was such that she needed to be in a facility where staffing levels ensured that this level of assistance could be provided i.e. Hospital level care.
- **24 Hour fluid restriction.** The fluid restriction related to her diagnosis of hypokalaemia and retention of fluid which occurred in the days following admission indicate the need for close monitoring by a Registered Nurse. Rest Home level facilities are not required to provide 24/7 presence of a Registered Nurse which is required at hospital level.
- **Incontinence**. It is also accepted practice that a person who has double incontinence is cared for in an environment where a Registered Nurse is available 24/7. It is significant that no background appears to have been provided as to the reason for [Mrs A's] incontinence.
- **Falls and medical events**. An InterRAI assessment would have triggered the fact that [Mrs A] had two falls while in [the public hospital]. It would also have

triggered her recent prolonged cellulitis, sepsis and Myocardial infarction. Each of these would have highlighted the need for at least a period of Hospital level care on discharge.

The combination of these factors would, I believe, point to the need for placement at Hospital level care. The almost immediate recurrence of [Mrs A's] cellulitis and retention of fluid would indicate that she was not well enough on discharge from [the public hospital] to be placed in Rest Home Level care.

I agree with the statement by [UCG] that [Mrs A's] health deteriorated very rapidly from the time of admission and it was clear that she was extremely unwell and not recovering from the sepsis for which she had been admitted to [the public hospital]. The review of the incident form (12 [Month3]) following the injury to [Mrs A's] arm states that she needed assessment for admission to a higher level of care.

The concerns raised by [Mrs A's] family include:

1) Injury following transfer with one person

As stated above the physiotherapist at [the public hospital] had indicated that [Mrs A] needed the assistance of one person. [Mrs A] and her husband reiterated this upon admission to Rhapsody. The initial careplan completed on the day of admission states 1 person assist. This information would have been taken from [the public hospital] notes and interview with [Mrs A] and her husband.

However the progress notes for the same day (9th [Month3]) state that caregivers reported that [Mrs A] was unsteady on her feet and required two people to transfer her. Further progress notes state that [Mrs A] required progressively more assistance throughout the week.

There did not appear to be an update to [Mrs A's] initial careplan stating that she needed two people to assist her.

2) The existence of a Careplan.

[Ms B] ([Mrs A's] daughter) states that on the 14th of [Month3] staff were asked by her sister-in-law if a careplan had been done for [Mrs A] and were told there was not one and that it takes two weeks to complete one.

In fact an initial care plan was completed on the day of admission (referred to above). This is in line with Facility Care Plan policy which states:

'1. Each Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan using the **5C1 Initial Nursing Assessment** to cover a period of up to 21 days, and that Registered Nurse input and agreement is sought and provided in developing and evaluating

the initial Care Plan in order to ensure continuity of relevant established support, care and treatments;

2. The assessment utilises information gained from the resident, their nominated representative (where applicable), and information provided by the Needs Assessment and Service Co-ordination Service and/or previous provider of health and personal care services along with observations and examinations carried out at the facility

3. At the time of admission an initial Care Plan is developed and documented based on information from the Resident's most recent interRAI home care assessment carried out and on any other information relevant to the initial Care Plan;'

Requirements of this policy that were not met were the availability of an InterRAI assessment and the updating of the initial careplan as [Mrs A's] mobility decreased and need for assistance increased. There is also no evidence that the following assessments were carried out during the first 24 hours in line with the Admission Policy:

- Norton Scale Risk Assessment (pressure area risk)
- Coombes Falls Assessment
- Nutritional Assessment and profile
- Oral assessment
- Continence assessment

Each of these would have provided objective information which may have helped in assessing [Mrs A's] health status and suitability for Rest Home level care, particularly in the absence of an InterRAI assessment.

It is also noted that [Mrs A] was being treated with Warfarin. There was no indication on the careplan of this. This is important in terms of monitoring her Warfarin levels (INR blood tests) and the need to be aware that patients on Warfarin are susceptible to bruising and prolonged bleeding.

[Mrs A's] fluid restriction was noted on the careplan but not the requirement for daily weighs related to this. However documentation provided indicates that these measures were being undertaken and documented in progress notes.

3) EPOA status and notification of incidents to [Mrs A's] husband

The Incident reports of 11th, 12th and 13th [Month3] all state that [Mrs A's] husband was contacted and informed.

In order for EPOA (Enduring Power of Attorney) to be enacted a GP needs deem the resident to have lost mental capacity. During his assessment of [Mrs A] on 15th of [Month3] the GP did not deem [Mrs A] to have lost mental capacity. This is evident

on the Resuscitation Decision form where the GP has stated that [Mrs A] was competent to make decisions.

[Mrs A's] husband was noted as next of kin on admission and as such appears to have been informed appropriately about incidents and [Mrs A's] progress.

4) The process of calling an ambulance.

The progress notes of 16th [Month3] (1530) indicate that nursing staff were aware of [Mrs A's] deterioration and the rapid progress of her cellulitis. They note that the GP had been called. At 1630 [Mrs A's] family requested that an ambulance be called. This request was supported by nursing staff and the GP.

a. What is the standard of care/accepted practice?

Accepted practice is firstly that patients are appropriately assessed using the InterRAI process prior to admission to a long term care facility. On admission to a long term care facility an Initial Careplan is developed within 24 hours of admission using information provided by an InterRAI assessment, discharge information, where appropriate, and the prescribed assessment tools (Norton Scale Risk Assessment (pressure area risk), Coombes Falls Assessment, Nutritional Assessment and profile, Oral assessment and Continence assessment).

It is accepted practice that where there is a rapid deterioration in a resident's health status that Registered Nurses assess the patient, document their findings and call for medical assistance when appropriate.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/ severe.

I believe there was a severe departure in terms of the decision made at [the public hospital] to move [Mrs A] into Rest Home level care as discussed above. She clearly had multiple medical problems along with decreased mobility, incontinence and ongoing major issues with skin integrity.

The combination of these issues and the lack of an InterRAI assessment flag the inappropriateness of transfer to Rest Home level care.

There was a severe departure in relation to the updating of the initial care plan. There is no evidence that the assessment tools mentioned above were used or documented. Their use would have provided a clear baseline in terms of [Mrs A's] rapid decline in mobility, self-care, cognition and skin integrity. While progress notes were of reasonable standard in terms of documentation of [Mrs A's] change in health status they need to be supported by robust assessment documents and accurate care plans to ensure that care is provided consistently and in line with a clear plan.

c. How would it be viewed by my peers?

My peers in practice and needs assessment would agree with my findings.

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

There needs to be adherence to the requirements of the Age Related Residential Agreement in terms of appropriate assessment and placement of residents into long term care facilities.

There also needs to be adherence to Facility policy in relation to Assessment and Documentation on the admission of a resident.

I am aware that in the light of the events of [Mrs A's] admission nursing staff meetings at Rhapsody have focussed on the importance of documentation and individualised comprehensive care planning. There has also been education on recognising and caring for the deteriorating patient.

6. The monitoring of [Mrs A's] cellulitis and various skin tears and whether this was in line with current nursing practice;

The discharge information provided to Rhapsody stated that [Mrs A] had an ulcer on her left lower leg and cellulitis on her left lower leg secondary to this ulcer and skin tears on her right arm (Nursing transfer form [the] District Health Board). In the initial assessment and careplan (09 [Month3]), completed on admission to Rhapsody, only the left lower leg ulcer was documented.

In the progress notes dated 09 [Month3] it is stated that along with the presence of the ulcer [Mrs A] was asking for pain relief for her right arm and had 'raw reddened area on her right groin'.

On the night shift of 10 [Month3] [Mrs A] was given paracetamol for pain in her right elbow. During the morning medication round her elbow was found to be swollen and hot and she had swelling in her hand.

The progress notes of 11 [Month3] indicate that [Mrs A] was seen by the wound care specialist and a request to complete the management plan in the wound care folder. The management plan was not included in the information provided.

The wound care specialist commented on the dressing of the ulcer but did not mention cellulitis.

The notes of 12 [Month3] refer to a dressing on the right elbow.

The notes of 15 [Month3] mention accumulation of fluid on left hand with peeling and signs of infection. A photograph was taken and shown to the GP.

Notes written at 1530 on 16 [Month3] state that cellulitis was present in both legs and right arm with breakdown of the wound on the left arm.

During the week that [Mrs A] was resident at Rhapsody there were three incident reports filed:

1) 11 [Month3] — A skin tear was noticed on [Mrs A's] left lower arm

2) 12 [Month3] — A skin tear occurred while transferring on Left lower arm.

3) 13 [Month3] — A skin tear noted on R) knee

The Resident Infection Summary lists a skin tear category 1b dated 11 [Month3] (no location supplied) and skin tear Right knee dated 13 [Month3].

Although it is mentioned that a plan was commenced on the Incident Form dated 12 [Month3] and the dressing instructions are provided on the Incident Form dated 11 [Month3] there is no documentation of wound assessment and care plans provided.

In her response to questions from HDC [UCG] confirms that there were skin tears to [Mrs A's] left lower arm on 2 consecutive days.

a. What is the standard of care/accepted practice?

The expected standard of care is that when wounds occur such as the skin tears on [Mrs A's] left arm and knee that an incident form is completed, next of kin are notified, and the incident is reviewed by a Registered Nurse. I am satisfied that this occurred in each case.

Following this process a wound assessment takes place and a wound care plan is developed for each wound. At each dressing the wound is assessed and observations are recorded (e.g. wound size, colour, and odour). Where cellulitis is present it is expected that an assessment and wound care plan is put in place. Along with the usual wound observations the progress of the cellulitis needs to be regularly documented through the use of photographs and mapping of the margins.

Given [Mrs A's] very recent history of cellulitis, the pain and redness in her elbow, and the presence of 4 skin tears and an ulcer on her leg it would be expected that there would be heightened vigilance for signs of cellulitis and immediate notification to the GP. It appears that symptoms were present on the day following admission (10 [Month3]) when [Mrs A] complained of pain in her elbow. The GP did not see [Mrs A] for a further 5 days (15th [Month3]) when he did her admission assessment.

It is also noted that the wound care specialist saw [Mrs A] on the 11th of [Month3] but appears to have assessed only the leg ulcer and I assume had not been notified of the arm wounds and pain in the elbow.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/ severe

There was, I believe, a severe departure in terms of documentation of assessment and treatment of [Mrs A's] wounds. Again information was documented in progress notes but not in a clear plan of care. Given [Mrs A's] history of cellulitis, falls and the risk for bruising and bleeding related to Warfarin treatment there was need for a much more co-ordinated approach to her care including nursing diagnoses and care planning related to the high risk for infection, poor skin integrity, poor circulation and decreasing mobility.

c. How would it be viewed by my peers?

My peers in education and practice would agree that there was a lack of clear documentation and co-ordination of care

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

Improvements to help prevent a similar occurrence include the use and documentation of assessment of skin integrity and treatment of wounds. Registered Nurses need to view residents in the light of their history and risk factors in order to make timely decisions around early intervention with a deteriorating patient.

References:

Age Related Residential Care Agreement 2019 https://tas.health.nz/assets/Health-of-Older-People/Age-Related-Residential-Care-Services-Agreement-2019-2.pdf

NB this agreement is dated […] after the events discussed in this reports. The amendments made to the 2018 agreement are not relevant to this case.

Report completed by:
Rachel Anne Parmee "

The following further advice was received from RN Parmee:

"Thank you for the opportunity to provide further advice on this case for which I provided initial advice on 25th July 2019.

I have been asked to review the following documents:

- Response to notification from Ultimate Care Group
- Response to request for information from [the DHB]
- Statement (received separately) from [the Clinical Services Manager]

and advise if any of the information provided causes you to change your initial advice and/or attribute responsibility to any individual providers.

Background

[Ms B] is concerned about the care that her late mother, [Mrs A], received from Ultimate Care Rhapsody during her residence there from 9 [Month3] until 16 [Month3].

On 9th [Month3], [Mrs A] moved into Ultimate Care Rhapsody after being discharged from [the public hospital], where she had been admitted for a period of 7 weeks whilst receiving treatment for left leg cellulitis, sepsis and hypokalaemia. Her discharge summary dated 1 [Month3] noted a left lower leg ulcer and a skin tear on her right forearm. Her initial assessment at Ultimate Care Rhapsody recorded her pulse at 68 (bpm), weight at 77.3(kg), blood pressure 115/60 and temperature 35.6 degrees Celsius.

On 11 [Month3], Registered Nurse [RN C] noticed a skin tear on [Mrs A's] lower left arm, and a plan was commenced to moisturise [Mrs A] regularly as her skin was very dry and fragile, and to transfer her slowly to prevent knocking her arms.

On 13th [Month3], [Mrs A] sustained an injury to her left arm and a small skin tear on her right knee following a fall. [Dr E], General Practitioner, attended to her on 15 [Month3] and prescribed a higher dosage of furosemide as she appeared to be retaining fluid and antibiotics for a skin infection. Later that day, nurses changing [Mrs A's] dressing reported fluid accumulation under the skin of her left hand, and that it appeared to be infected. [Dr E] advised her to continue with the antibiotics.

On 16th [Month3], it was noted by nursing staff that her left lower arm wound had broken down further and the cellulitis had increased on both her legs and hand. [Mrs A's] condition began to deteriorate throughout the day. Upon assessment of her vitals, her temperature was recorded at 36.3 degrees Celsius, her pulse at 86 bpm and blood pressure 135/70. She was struggling to eat and swallow. This prompted [RN C] to consult [Dr E] for his advice.

[Mrs A] was later admitted to [the public hospital] by ambulance, at the request of her family, where she later passed away on 17th [Month3].

Review of documents

The issues raised by [UCG] in relation to my initial advice include:

a) The updating of [Mrs A's] careplan, including that there is no evidence that various assessment tools were used, and that [Mrs A's] warfarin prescription was not recorded in the care plan

b) The documentation and assessment of [Mrs A's] wounds.

The updating of [Mrs A's] careplan, including that there is no evidence that various assessment tools were used, and that [Mrs A's] warfarin prescription was not recorded in the care plan

[UCG] acknowledges that [Mrs A's] warfarin prescription was not noted on the careplan along with the important interventions associated with the care of a person on warfarin.

In my initial report I stated that:

> There is also no evidence that the following assessments were carried out during the first 24 hours in line with the Admission Policy:
>
> - Norton Scale Risk Assessment (pressure area risk)
> - Coombes Falls Assessment
> - Nutritional Assessment and profile
> - Oral assessment
> - Continence assessment

[UCG] provides a list and evidence of the tools used in the initial assessment of [Mrs A] as part of the admission process. These include:

a) Norton Scale Risk Assessment/Pressure Area Risk completed on the second day of admission.

b) Coombes Fall Assessment dated second day of admission (not signed by RN)

c) Oral and Nutritional profile completed and signed day of admission.

d) Continence assessment day of admission completed and signed

I am satisfied that the requirements of the admission policy in terms of assessment were met.

Therefore, I would like to remove my finding that there was a severe departure in terms of assessment tools not being utilised as part of the admission process.

I still maintain that there was a severe departure in terms of the decision made at [the public hospital] to move [Mrs A] into Rest Home level care as discussed above. She clearly had multiple medical problems along with decreased mobility, incontinence and ongoing major issues with skin integrity.

The combination of these issues and the lack of an InterRAI assessment flag the inappropriateness of transfer to Rest Home level care.

The documentation and assessment of [Mrs A's] wounds.

In my initial report I stated:

> The discharge information provided to Rhapsody stated that [Mrs A] had an ulcer on her left lower leg and cellulitis on her left lower leg secondary to this ulcer and

skin tears on her right arm (Nursing transfer form [DHB]). In the initial assessment and careplan (09 [Month3]), completed on admission to Rhapsody, only the left lower leg ulcer was documented.

In the progress notes dated 09 [Month3] it is stated that along with the presence of the ulcer [Mrs A] was asking for pain relief for her right arm and had 'raw reddened area on her right groin'.

On the night shift of 10 [Month3] [Mrs A] was given paracetamol for pain in her right elbow. During the morning medication round her elbow was found to be swollen and hot and she had swelling in her hand.

The progress notes of 11 [Month3] indicate that [Mrs A] was seen by the wound care specialist and a request to complete the management plan in the wound care folder. The management plan was not included in the information provided.

The wound care specialist commented on the dressing of the ulcer but did not mention cellulitis.

The notes of 12 [Month3] refer to a dressing on the right elbow.

The notes of 15 [Month3] mention accumulation of fluid on left hand with peeling and signs of infection. A photograph was taken and shown to the GP.

Notes written at 1530 on 16 [Month3] state that cellulitis was present in both legs and right arm with breakdown of the wound on the left arm.

During the week that [Mrs A] was resident at Rhapsody there were three incident reports filed

1) 11 [Month3] — A skin tear was noticed on [Mrs A's] left lower arm
2) 12 [Month3] — A skin tear occurred while transferring on Left lower arm
3) 13 [Month3] — A skin tear noted on R) knee

The Resident Infection Summary lists a skin tear category 1b dated 11 [Month3] (no location supplied) and skin tear Right knee dated 13 [Month3].

Although it is mentioned that a plan was commenced on the Incident Form dated 12 [Month3] and the dressing instructions are provided on the Incident Form dated 11 [Month3] there is no documentation of wound assessment and care plans provided.

The documentation since provided includes:

a) A short-term care plan for the left lower leg wound
b) Wound, skin assessment and treatment forms which include each of [Mrs A's] wounds.

Therefore, I would like to alter my initial finding to state that:

Wound, skin assessment and treatment forms were completed. However, where cellulitis is present it is expected that along with the usual wound observations the progress of the cellulitis needs to be regularly documented using photographs and mapping of the margins.

There was, I believe, a severe departure in terms of documentation of assessment and care planning for [Mrs A]. Given [Mrs A's] history of cellulitis, falls and the risk for bruising and bleeding related to Warfarin treatment there was need for a much more coordinated approach to her care including nursing diagnoses and care planning related to the high risk for infection, poor skin integrity, poor circulation and decreasing mobility.

In conclusion, I am satisfied that the initial assessment documents were completed according to the facility's admission policy. I am also satisfied that appropriate assessment and documentation was completed in relation to [Mrs A's] wounds.

However, I maintain that there was a severe departure in terms of the decision made at [the public hospital] to move [Mrs A] into Rest Home level care as discussed above. She clearly had multiple medical problems along with decreased mobility, incontinence and ongoing major issues with skin integrity.

I also maintain that there was a severe departure with the omission of reference to [Mrs A] being prescribed Warfarin and the consequent care issues.

I maintain my finding of severe departure in terms of documentation of assessment and care planning for [Mrs A] related to her recent history of cellulitis, high risk for infection, poor skin integrity, poor circulation and decreasing mobility.

I am unable to attribute responsibility for these departures to any individual provider. Please do not hesitate to contact me should further advice and clarification be required.

Rachel Parmee"