A Rest Home

Nurse Manager of the Rest Home, Mrs C

General Practitioners, Drs D and E

A Report by the

Health and Disability Commissioner

(Case 02HDC17712)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Miss A	Complainant / Consumer's sister
Miss B (dec)	Consumer
Mrs C	Provider / Nurse Manager of the rest home
Dr D	Provider / General Practitioner
Dr E	Provider / General Practitioner
Mrs F	Provider / Registered Nurse
Mr and Mrs G	Provider / Owner & Licensee of the rest home
Ms H	Wound Nurse
Dr I	Geriatric Hospital general practitioner

Complaint

On 28 November 2002 the Commissioner received a complaint from Miss A about the services provided to her sister, the late Miss B, by nurse manager Mrs C, at a rest home (owned by a family foundation). The complaint was summarised as follows:

The rest home did not provide services of an appropriate standard to Miss B. In particular, the rest home:

- *refused to seek medical assessment and treatment for Miss B when she developed ulcers on her feet. Miss B should have been prescribed antibiotics*
- *did not seek medical assessment and treatment for Miss B when she developed ulcers on her hips.*

The Commissioner commenced an investigation on 27 February 2003. As a result of the advice provided by the nurse advisor the investigation was extended to include general practitioners Drs D and E on 17 October 2003, and registered nurse Mrs F on 8 December 2003.

In relation to Dr D, the following issue was identified for investigation:

- *whether your assessment and treatment of Miss B between 14 July and 14 August 2002 was of an appropriate standard.*

In relation to Dr E and Mrs F, the following issue was identified for investigation:

- *whether your assessment and treatment of Miss B while she was a resident at the rest home was of an appropriate standard.*

Information reviewed

- Miss B's medical records from the public hospital
- Ministry of Health Audit of the rest home
- Miss B's medical records from Dr E, Dr D and the rest home
- Miss B's medical records from the geriatric hospital
- Diary of events from Disability Support Link
- Expert advice obtained from an independent nurse consultant, Ms Jenny Baker

Information gathered during investigation

Background
Miss B was born in1924 and lived with her older sister, Miss A, in a retirement village in a town.

Miss B was admitted to a ward at a public hospital on 16 June 2002 with increasing loss of function, drowsiness, gradual loss of cognitive function and coordination over the previous two or three years, and dementia. She was noted to have a reddened area on her buttocks (19 June), and also had a basal cell carcinoma on her left calf, which was excised on 26 June. After her surgery, Miss B required dressings to three wounds – a skin graft wound on her left leg, an ulcerated area on her right lower leg, and the donor site on her left thigh. Generally her skin was frail and prone to tears and bruising.

Miss B was transferred to another ward at the same hospital for rehabilitation on 5 July. Her initial assessment indicated that she could walk with the aid of a stick or walker with minimal risk of falling, and was able to look after her own grooming with minimal supervision. She was incontinent on occasion. While at the rehabilitation centre, Miss B was assessed as "medium risk" of developing bed sores. She was turned two hourly and nursed on an air mattress. On 14 July Miss B complained of painful heels. The nurse applied cream to her heels and noted a haematoma the size of a 20 cent coin surrounded by an inflamed patch extending the size to that of a 50 cent coin. She received physiotherapy and occupational therapy in an effort to improve her independence. By 16 July Miss B was able to mobilise independently around her room. Her main medical problem was dementia, and blood tests indicated that she could be diabetic.

It is clear from Miss B's hospital records that her sister, Miss A, wanted Miss B to come home to the unit they shared together. A physiotherapist and occupational therapist visited Miss B's home to prepare for her arrival. However, staff at the rehabilitation centre had some concerns about Miss A's ability to care for her sister and arranged a rest home placement for 27 July. Miss B was discharged home with district nurse support on 16 July. A discharge summary was sent to Miss B's general practitioners, Dr … in her former hometown and Dr D in her present hometown. Miss A and Miss B had lived in one town and recently moved to another town, hence the change in doctors. A referral was also sent

to a district nurse requesting that she assess whether Miss A could manage the care her sister required, and redress her leg wounds daily.

Transfer to the rest home
Miss A was unable to care for Miss B, who became increasingly dependent without constant stimulation in her daily routine. By 22 July Miss B was spending all day in bed sleeping. The district nurse, who had been visiting daily, contacted Dr D to arrange Miss B's transfer to a rest home. Dr D confirmed the district nurse's concerns and completed the referral form, which he faxed to Disability Support Link (DSL), stating, "[Miss A] thought she could take care of [Miss B] but cannot. [Miss B] is presently confined to bed and cannot do anything for herself whatsoever. Referred for urgent care to [the rest home] – please assess her there." Dr D did not assess Miss B as he expected DSL to do so in the rest home.

On 22 July 2002 Miss B was transferred to the rest home, which is close to the sisters' home, so that Miss A could visit daily.

Nursing and medical staff
The licensee and owners of the rest home are Mr and Mrs G (the Foundation), who reside in a city. The Nurse Manager is Mrs C, an enrolled nurse with many years' experience nursing the elderly. She commenced employment at the rest home in April 2002.

Mr G advised me that when the position for nurse manager became vacant the best applicant was Mrs C, but the position description called for a registered nurse. She provided a reference from her previous employer, who spoke highly of her skills as a team leader and dedication to nursing the elderly. He sought approval to employ Mrs C from the Ministry of Health, and it was granted on 8 April 2002. However, the Ministry of Health gave approval to appoint Mrs C as manager, and not nurse manager as indicated by Mr G.

Mr G sent me a copy of Mrs C's job description, which lists the following clinical specifications:

"**Clinical Specifications:**

Resident Admission and Monitoring	New residents to have health needs identified to ensure service capability.
Planning Healthcare	To provide a personal care program for each resident including goals for their : Safety : Health care : Rehabilitation : Individuality/Independence : Daily living skills : Community involvement : Multi disciplinary care : Medical review

To provide healthcare services in accordance with the principle of promoting each resident's independence and participation in activities of daily living.

To put in place systems for co-ordinating care planning.
To put in place procedures for safe medication practice.
To maintain safety standards within the home and support orientation for staff.
To have strong skills in the area of staff supervision and leadership.
To be accountable for own clinical practice and professional development.
To be available for staff meeting and staff training sessions and any other meetings deemed necessary.
Ensure all incidents/accidents, hazards are reported promptly, and all work is consistent with the rest home's health and safety policy and procedures.
To monitor health care intervention to ensure residents' goals are achieved/able.
Staff to be provided with ongoing opportunities for personal and career development.
To provide access for clients to specialist medical/allied health services.
To monitor health care intervention to ensure resident's goals are achieved/able."

Because Mrs C was an enrolled nurse the Foundation employed a registered nurse, Mrs F, to manage any clinical deficiencies. The difference in terms of scope of practice between the two is important because, as well as legislative differences, the Nursing Council of New Zealand (the Council) defined the differences between enrolled and registered nurses in terms of their preparation to practise. The programme leading to enrolment prepares the nurse to care for people who have relatively stable and predictable health outcomes, and focuses on maintaining and safeguarding their comfort and dignity, and promoting their health and safety.

Mrs F was registered with the Council in 1953 and appointed as a public health nurse in 1979. She attended training days regularly, to keep her knowledge current, but the subjects related to public health initiatives rather than individual nursing care. Although a registered nurse, at the rest home Mrs F worked under the instruction of Mrs C, something she said she did "diligently". For "problem cases" she would telephone Mrs C and was only allowed to use her initiative in an emergency. She advised me that she only went to work at the rest home because Mrs G's parents were family friends. This may explain why the arrangements were not formalised. She told Mrs G that she had not done geriatric work before.

Mrs F worked up to three shifts a week as a casual relief public health nurse, and four hours a day on Saturday and Sunday at the rest home. She signed an individual employment contract but was not given a job description (it would have been the same description as Mrs C was employed under) for her responsibilities at the rest home until 6 November 2002 (she commenced work on 23 March 2002). Mrs F advised me that the job description was obviously for a full-time registered nurse and it was impossible to complete its expectations working only eight hours a week. She thought her role was supervising the staff caring for the residents and changing wound dressings. Sometimes she would need to start early to complete her work. As Miss B deteriorated, her dressings took longer to complete. She was not told, nor did she expect, that part of her role would be supervising the manager. That would have been impossible as they never worked at the same time, and

she was the "boss". Mrs C was very experienced, with a background in aged care; she had also worked in surgical wards and was familiar with wound management. Mrs F knew nothing, nor would she have expected to be told, about the Ministry of Health's contract with the rest home.

There is some confusion about Mrs F's on-call hours. Mr G and Mrs C understood that Mrs F was on call during weekdays and on public holidays, and on duty on the weekends. Mrs F advised me that she commenced employment on 23 March 2002 and told Mrs G that she could not be on call during the week because she had other employment. She made this clear when she accepted the position. She was on call at the weekend only when Mrs C had the weekend off. She agreed to work at the rest home because Mrs G could not find another registered nurse and was "desperate".

When asked about the relationship between Mrs C and Mrs F, Mr G advised me as follows:

> " … Fortunately there is little if any duties that [Mrs F] performs which is not already done by [Mrs C] or that [Mrs C] is not capable of. [Mrs F] is involved in all the writing up of the care plans and she also signs off all these relevant paper work. [Mrs C], like [Mrs F], is very competent in providing all the nursing requirements and if in doubt both would usually consult our GP. [Mrs F] normally handles all the nursing duties during her shifts as well."

Mrs C was not given any orientation to her new position at the rest home by the previous nurse manager but Mrs G spent two weeks with her at the commencement of her employment. Mr G advised me that Mrs G "has a comprehensive knowledge of [the rest home] and its operating procedures. She is involved in most day to day activities, audits etc." Mrs G is not a nurse and does not have a medical background.

The rest home's general practitioner was Dr E. Under the Ministry of Health contract he was required to review patient medical care and medications every three months, unless a particular medical problem was brought to his attention. However, the medical care of respite care residents at the rest home was monitored by their own general practitioner. Mrs C understood that Miss A was keen for Miss B's own general practitioner, Dr D, to be consulted about medical matters. Miss A said that she understood the rest home had its own doctor and wondered why the rest home doctor did not see Miss B. She thought that Mrs C would not call the doctor because the rest home would have to pay. She did not know that her sister was a subsidised patient. Eventually Miss A contacted Dr D, to ask him how she could get a doctor to see her sister because Mrs C had refused.

Nursing and medical care

Miss B was admitted to the rest home on 22 July 2002. The admission assessment described her as "grossly dehydrated"; she required the assistance of two carers for mobility, and was incapable of showering or bathing independently. Her skin was particularly fragile, tearing easily, and she had blisters on both heels. Miss B was considered at high risk of developing bed sores. She had Duoderm applied to both heels for protection purposes, and was nursed on an air bed mattress. Mrs C recorded the following in Miss B's notes on 22 July:

> "Urgent admission today for respite care, sister unable to manage at home. To remain on bed rest but up to toileting on commode. Please push fluids as has not passed urine in last 24 hours. … Please be very careful of her skin as it is very thin and high risk of breaking down. Admitted with blisters on heels, covered with Duoderm. Carcinoma taken off left leg, dressing intact."

On 25 July Mrs C commenced a "bruise chart" because she had noticed some bruising on Miss B's arms. On 26 July DSL assessed Miss B at the rest home with her sister, Miss A, present. It was arranged that Miss B would be assessed again "over the next few days to see if her condition stabilises or improves". Mrs C advised me that she was not given any information about the assessments from DSL and there is no record of the assessment in Miss B's notes. The assessment record indicates that an assessor spoke to Mrs C on 31 July about Miss B's dependence on nursing services.

Nursing assessment

Mrs C completed Miss B's nursing assessment on 26 and 27 July. Her instructions were for Miss B to be walked to the dining room (with the aid of two carers) for lunch and dinner, and to be encouraged to feed herself. Mrs C asked for Miss B to be helped with fluids as she was dehydrated (having not passed urine in the past 24 hours), placed on a fluid balance chart, and toileted regularly (as she could be incontinent). She assessed that Miss B had poor balance and was at risk of falling, had frail skin that was easily torn, and had a high risk of developing bed sores. She was nursed on an air mattress. Mrs C recorded "attention to heels" and applied Duoderm to both of Miss B's heels.

On 27 July Mrs C re-applied Duoderm to both of Miss B's heels "as they were looking sore and are going to break down, extreme care needed".

Mrs F first saw Miss B when she worked the weekend of 27 and 28 July. Because she was not a full-time staff member and was only relieving, Mrs C communicated specific residents' needs by telephone or "written instruction". It was customary for Mrs C to complete care plans.

On 27 July Mrs C noted the following in Miss B's notes:

> "Fluids to be continued being pushed and importance accurate fluid balance kept. Duoderm applied to both heels as looking sore and are going to break down, extreme care needed."

According to the nursing records Miss B improved initially. She was eating and drinking, walking to the dining room (with assistance) and appeared to look forward to visitors and activities, such as a barbecue, organised by the rest home. By 5 August she was feeding herself and her diet was supplemented with Resource. At other times she was sleepy and refused to open her mouth or eyes and often fell asleep for short periods of time during visiting hours.

On 7 August Miss B was assessed again by DSL. They advised me that "following review and discussion with [the rest home] [it was] agreed long term residential care appropriate. However, sister [Miss A] [is] keen to have [Miss B] home – six week review." DSL

applied to the Ministry for residential care funding. Mrs C advised me that she received no information from DSL's assessment and there is no record in the nursing notes. Miss B was assessed as SNL 4. It was agreed that she would be reviewed again in six weeks. Miss B was approved for rest home placement on 8 August.

By 9 August Miss B was refusing to walk and was sometimes uncooperative when attempts were made to dress her. On 11 August the carers noted discolouration around Miss B's ankle. The protection pads were lifting off, and her heels had an offensive odour. Any urine captured was noted to be "cloudy".

Ulcer management
On 12 August Mrs C debrided and re-dressed Miss B's heels. Miss B's ulcers were infected and she required antibiotics. Mrs C telephoned "the doctor" but there is no indication that her call was returned. She instructed her carers to leave Miss B in bed that day rather than take her to the shower or dining room, and to keep her feet dry, elevated and free from pressure from bedding, etc.

Mrs C said that she telephoned Dr D about Miss B's feet on several occasions but he did not return her calls. She understood that this was because it was not practical for him to visit a single patient. Dr D had other residents in the rest home but their relatives usually took them to him at his practice in his town. Dr D cannot recall being contacted by the rest home and denies that he would have refused to see Miss B if he was asked to do so.

Miss A advised me that she contacted Dr D about her sister's ulcers, but was unable to recall the dates. Dr D also has not recorded dates, but recalled telephoning Dr E about Miss A's concerns. Dr E saw Miss B soon after.

Mrs C debrided Miss B's heels on 14 August. Miss B's nursing records indicate that, on 14 August, Dr D was contacted because the ulcers on Miss B's heels were infected. Dr D did not attend but he prescribed the antibiotic flucloxacillin, three times a day for seven days, and requested swabs of the ulcers to be sent to the laboratory. Dr D confirmed that he was contacted on 14 August but he did not order swabs as they had been taken by the rest home staff. He did not follow up the results of the swabs or assess Miss B because he thought Dr E was her doctor.

On 16 August Miss B had conjunctivitis and had sustained several skin tears. Mrs C said that Miss B needed medical attention and she asked Miss A whether Dr E could examine Miss B's feet. Miss A gave consent and Mrs C faxed Dr D to inform him that Miss B had been transferred to Dr E.

Mrs F dressed Miss B's heels on 17 and 18 August and noted some improvement on the second day, as there did not seem to be so much exudate. Miss B's appetite was improving; she was eating all her meals at breakfast and lunch but less in the evening. She was also spending time in the lounge with other residents.

Dr E received a note from Dr D about Miss B's recent medical history and understood that her admission to the rest home was to be short term. Dr E saw Miss B for the first time on 21 August. He found a 5cm shallow ulcer on her right heel and a 3cm ulcer on her left heel.

Each contained a little purulent material but she exhibited no other signs of infection. Her antibiotics were due to finish the following day and he saw no reason to continue them. He discussed wound management with Mrs C, including her diet, which he considered "remarkably good". He knew she was on antibiotics. He ordered blood tests, including a full blood count, liver and renal tests and blood sugar levels. Dr E advised me that Miss B was severely demented but she appeared comfortable and not distressed.

Mrs C recorded "see by Dr today as has now been put under [Dr E]. Commenced on Zinc and Vitamin C tablets. To hairdresser for a perm. Do not wash her hair tomorrow".

On 26 August one of the carers on evening duty recorded:

> "Ate a good tea feeling good today. Turned at 10.30. Please turn through the night 2hrly off hips. Last turned @ 10.30."

Mrs C re-dressed Miss B's ulcers on 27, 28 and 30 August. She reported an improvement in both right and left heels. On 30 August the notes record "continue to take care of both hips – Duoderm to remain on". One of the carers recorded that "the bandage and dressing was coming off right heel" on 1 September. She telephoned Mrs C, who gave permission for the dressing to be reapplied.

On 2 September 2002 Mrs C renewed Miss B's dressings. She recorded the following: "left heel healing well, right heel debrided of dead skin and now looks better. Duoderm renewed on both hips. Right hip skin broken so please keep [Miss B] sitting up during the day and to only relax on back and left side during the night." On 3 September staff reported an "offensive odour" and "leaking" from Miss B's heels. On 5 September the staff recorded Miss A's concerns about Miss B's feet and asked for medical attention.

Dr E saw Miss B again on 6 September. There was no change in her condition and the bed sores did not look significantly different although they were drier, with signs of "granulation" around the edges. Dr E said that Miss A was present when he examined Miss B and they discussed her care. Miss A wanted Miss B to come home and was visibly upset when he advised against it. Miss A had had no nursing experience and knew that she could not look after her sister at home, because of the risk of her falling and breaking her pelvis.

Later that day Dr E discussed Miss B's management with the registrar at the Plastics Clinic, of the public hospital and was advised to continue the present treatment as "Admission not going to assist at this stage", but to send a referral to the hospital's Plastic Clinic. Dr E's referral to the Plastic Clinic stated:

> "Please arrange an appointment for this woman who is previously known to the service. … She developed pressure sores on both feet about 6 weeks ago and they are proving slow to heal. At this time there are no symptoms or signs of infection and they are really at a standstill. One is on the right heel and about 5cm diameter and the other is a smaller one on the left lateral ankle. Peripheral pulses are present but reduced more so on the left.

> She suffers from dementia but seems to be comfortable. She is a NIDDM (non insulin dependent diabetes mellitus) (diet only). I have attached copies of lab findings. The graft looks satisfactory."

On 8 and 9 September Mrs F reported oozing from the ulcers on Miss B's heels, and Dr E commenced Miss B on amoxycillin/clavulanic acid antibiotics (three daily for 14 days) on 11 September (reducing to two a day from 25 September).

Dr E recalled discussing with Mrs C whether Miss B should be reassessed for higher level care. The staff felt that they were coping well and there was little more that could be done. Neither Dr E, Mrs C nor Mrs F knew about the wound resource nurse at the hospital, Ms H, or that she visited rest homes. Dr E said that even if he had known about this service he would not have considered a referral because he considered that Miss B was receiving good nursing care.

On 12 September an unknown nurse reported a "pressure sore on the inside of [Miss B's] buttocks" and the following day a small broken area on her right hip. Both ulcers were treated with Duoderm and Betadine. Over the following days Miss B's heel dressings were changed more frequently. Her nursing records are extensive, recording when she was in and out of bed and was turned, and what she ate at meal times. Notwithstanding the nursing care, her ulcers deteriorated. Miss B's dressings on her heels were changed three times a day and she sustained frequent skin tears. She was seen by Dr E on 25 September, with no alteration in her care.

Miss B's nursing notes record two-hourly turning during the day and turns two to three times during the night. It became difficult to turn her into a position where she did not develop pressure sores, and her carers used pillows to relieve the pressure. She was stood regularly, sometimes as often as quarter hourly, in an effort to improve her circulation. Miss B was also now frequently incontinent, which added to her skin problems. The evidence is that she continued to eat well and enjoyed social activities such as bingo, listening to music, and being read the newspaper. Mrs C found it surprising that Miss B did not complain of pain.

Neither Miss A nor Dr E knew that Miss B was developing bed sores on her hips. Mrs C was surprised to learn that Miss B's ulcers, especially those on her hips, had not been discussed with Miss A, and understood that Dr E read Miss B's nursing records before his morning rounds and knew of the deterioration.

Documentation (hips and buttocks)
After carefully reading Miss B's notes I can find very little information about the state of her hips and development of ulcers. Her notes contain no mention of a hip ulcer until 2 September, when the skin had broken on her right hip. Dr E saw Miss B on 6 September but there is no indication that he was told about her hips. Mrs C recorded:

> "Seen by Dr today as per request from sister. Wounds are dry and left heel [reduced] in size. Right heel unchanged. Commenced on Ferrogradumet. Please do not give sugar as she is a Diet Controlled Diabetic. Dressing to continue as happening. Please do not

shower over the weekend as I want to keep her bandages dry. Please elevate bottom of bed when in it resting."

Mrs F redressed Miss B's heels with Paranet and zinc ointment on 7 and 8 September but there is no information about her hips. Mrs F advised that she redressed the ulcers on Miss B's feet but Mrs C had covered the ulcers on Miss B's hips with Duoderm and they were not to be disturbed. It is recorded by one of the carers on the evening of 8 September that Miss B was "[o]ozing from dressing on R side. Gauze packing applied and micropore tape to help with seepage, otherwise good this duty."

On 9 September Mrs C attended to Miss B's dressings but there is no record of dressing changes on 10 September. Dr E was told about the infection to her heels on 11 September (but nothing about her hips). Mrs C recorded the following:

"Seen by Dr today re dressings on feet. Commenced on A/B, continue with dressings, encourage leg exercises."

Miss B was noted to have a pressure sore on her "bum" on 12 September, and on 13 September a small broken area on her right hip was noted and covered with Duoderm. Betadine was applied to the broken area on her bottom on 15 and 17 September. Mrs F changed Miss B's dressings on her heels on 14, 15, 21, 22, 28 and 29 September, but no reference was made to ulcers on her hips or buttocks. On 23 September a carer recorded "inside L calf weeping fluid, and old blood the size of 50c piece on pillow between legs. Melolin and bandaged for protection."

On 7 October one of the evening carers recorded:

"Dressing to L and R heels and feet done at 3.45. Sister ([Miss A]) insisted she be present and expressed her concern about not being informed on [Miss B's] condition. [Miss B's] 'odour' being found very strong and drifts smell in dining room and lounge to discomfort to other residents and staff."

On 12 and 13 October Mrs F redressed the ulcers on Miss B's heels. She recorded that the ulcer on the right heel was "drier" but still had some "oozing"; the right hip was not so red looking at the edges but was "still suppurating"; and the left hip was not so inflamed looking. Mrs C redressed the ulcers on 15 October but there is no record of her assessment. On 16 October Mrs C redressed the ulcers, reporting the heel wounds as "getting smaller" and the ulcers as "clean".

DSL advised me that Miss B was assessed at the rest home on 16 October. The records indicate that DSL received a phone call from another rest home (also a geriatric hospital) on 17 October to inform them that Miss B had been transferred and they believed her to be level 5 (hospital care).

DSL records indicate that the assessor completed an assessment on Miss B but the date is uncertain. The assessor reported the following:

"Presently has ulcers on feet and hips.

> Medication – takes a while to swallow tablets. Sister moving her to hospital at 2pm today. Assessor unable to see areas. They had just been redressed."

Miss B was transferred to the geriatric hospital. Mrs C was not notified of the change of status or informed that Miss B was to be transferred, and there is no record of the assessment in her notes. However, Mrs C recorded the following in Miss B's records: "Dressings redone, heel wounds getting smaller, hips clean. Transferred to [the geriatric hospital] 2.30pm via ambulance. Notes sent with ambulance officer." Mrs C provided a discharge summary to accompany Miss B.

Mrs C indicated that she was informed the day before that Miss B was going to be transferred to another home and she prepared a discharge summary. Mrs C did not document this in Miss B's records on 15 October and the discharge summary is not dated. Mrs C advised the geriatric hospital of the following:

> "… [Miss B] came to us as an urgent admission as her sister was unable to manage her at home. She had large blisters on both feet when she came and they have been trying to heal them ever since. Her hips were very red and blisters formed and one of these has broken down and the other will do the same in time, we are still trying to heal these, they are healing but it is a very slow process. All of the wounds were being treated with Paranet and have responded to it.
>
> [Miss B] walked only one day with the assistance of two nurses and we took most of the weight as she walked with her knees bent. She told us she did not want to walk any more and could not see why she should.
>
> [Miss B] was very confused and very dehydrated as she had not passed urine within the previous 24 hours. She had an awful rash in her groin which is now healed and her skin needs extreme care as she receives skin tears very easily.
>
> We have had her up in the morning and on the bed for a rest, but her family did not like this and thought she should be up and awake to talk to them. If left up to [Miss B] will go to sleep in the armchair, which also upset her family.
>
> [Miss B] will feed herself with encouragement from the staff most days but can also need feeding some days, she enjoys her puddings and will usually have no problem feeding herself with these.
>
> Incontinence products are worn both day and night and also required to be toileted 2 hourly.
>
> Medications are as follows:
>
> | | |
> |---|---|
> | Vitamin C | Daily |
> | Zinc Tabs | Daily |
> | Thyroxine 100mg | Daily |
> | Paracetamol 500mg | Q.I.D |
> | Atorvastatin 10mg | Daily |
> | Ferrogradumet | Daily |

Her bowels were open yesterday.

[Miss B] was last seen on 09-10-2002 for review of her wounds. …

Following a blood test on the 23-08-02 we found her glucose 9.4 and has been on a diet controlled diabetic regime since."

Geriatric hospital care

The records from the geriatric hospital indicate that Miss B was admitted on 16 October at 5pm. On 18 October Miss B was seen by the geriatric hospital general practitioner, Dr I. He took swabs and commenced flucloxacillin three times a day for seven days and referred her to Ms H. On 24 October Ms H assessed Miss B's ulcers.

At the geriatric hospital Miss B was turned two hourly, and nursed on a ripple mattress. Dietary supplements (Ensure and Two Cal) were ordered by the dietician. Miss B was given pain relief (Panadol) and the antibiotics flucloxacillin and Synermox. Dr I suggested a consultation with the Plastics Clinic. Wound swabs taken on 18 October revealed Staphylococcus infection in her right and left hips and right heel ulcers. Ms H also suspected Pseudomonas infection when she examined Miss B on 24 October.

By 26 November Miss B's ulcers were showing some improvement but the following day she was generally unwell. Miss B died at the geriatric hospital on 27 November 2002 at 3.45pm. Dr I believed that Miss B's death was likely to have resulted from wound sepsis.

Complaint re transfer

On 31 October 2002 Mrs C received a letter from the charge nurse at the geriatric hospital. The letter stated:

"I am writing to express my concerns regarding [Miss B] who was transferred to us on the 16 October from your Rest Home.

The transfer letter did not truly reflect the extensive nature of the pressure ulcers and poor general condition of the patient, nor the extent of the knee contractures. The transfer letter stated on admission 'Her hips were very red and blisters formed and one of these have broken down and the other one will do the same in time'.

We were shocked on examining [Miss B] shortly after admission to find a very large full thickness pressure ulcer on her right hip measuring 9cm x 7cm and so deep it was down to the hip ligaments at one end. The other hip had a necrotic area measuring 6cm x 5cm with surrounding redness indicative of severe tissue damage. These required referral to [Ms H] (wound resource nurse) from [the public hospital] to seek advice on the appropriate dressings and management. I'm not sure if you are aware that this is available to Rest Homes.

There is evidence of Staph Aureus and Pseudomonas infections in the left foot, right heel and hip ulcers, which required treatment with antibiotics.

I realise that you were not told where [Miss B] was moving to, and only given very short notice of transfer, but a more accurate reflection of her overall condition would have been appreciated."

Ministry of Health Audit
On 25 September 2002 the Ministry of Health conducted an audit of the rest home. The nursing audit identified 28 service specifications "partially attained" and ten "unattained". It was found that the rest home's policies and procedures did not reflect nursing practice and, in other areas, no policy and procedures were written. The audit report noted that "The Nurse Manager is new to the role of Manager and has found her new position both a challenge and a little stressful taking home work to do at night". The unattained and partially attained service specifications identified as relevant to this case include the following:

"Assessment & Care planning
- RN initial care plan
- Unplanned admissions
- Care plan review
- Resident input
- Admission assessment
- Nursing assessment
- Problem goals
- Relative notification
- Individual activity plan
- Programme evaluation
- GP examination < 2 days from admission"

Mrs C was responsible for meeting the deficiencies identified. The verification audit, conducted on 28 April 2003, found some improvement, with 19 partial attainments and two areas "unattained". Many of the partially attained policy areas are relevant in this case and include wound care, pain management, written records for nursing and general practitioner management, admission assessment, and nursing care planning. The report concluded:

"…

- There was no documented process for the development of a Care Plan, insufficient evidence of Care Plans having been reviewed and all Clinical Record documentation was incomplete. Care plans were not signed off as developed by the Registered Nurse. Documentation lacked a professional completion of full date, signature and designation of person scribing these.
- Quality improvement programme was insufficiently documented and monitoring/evaluation against service delivery was not evident.
- Admission agreement not fully implemented."

Independent advice to Commissioner

The following expert advice was obtained from an independent nurse consultant, Ms Jenny Baker:

> "I have been asked to provide an opinion to the Health and Disability Commissioner on Case No 02/17712/… and I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.
>
> …
>
> This is the second report I have been asked to write on this case. The purpose of this second report is to again [the first report initiated further investigation] advise the Commissioner on whether [Miss B] received an appropriate standard of care at [the rest home], based on significant new information.
>
> The scope of my report required is: *To advise the Commissioner on whether [the rest home] provided services of an appropriate standard and, in addition, to answer the following questions:*
>
> - *What particular standards apply in this case?*
> - *Did the care provided by [the rest home] meet those standards and, if not, how was the care deficient?*
> - *Should [Miss B] have had medical assistance and treatment to ulcers on her feet sooner?*
> - *Should [the rest home] have sought a prescription for antibiotics for [Miss B] sooner?*
> - *Should [the rest home] have sought medical assessment and treatment when [Miss B] developed ulcers on her hips?*
>
> *Any other matter which, in your opinion, should be brought to the Commissioner's attention.*
>
> **Documentation reviewed during this report**
>
> - [Miss B's] letter to the Commissioner and records of telephone conversation (pages 1-5) marked 'A'
> - The Commissioner's notification letter to [the rest home] (pages 6-8) marked 'B'
> - Response on behalf of [the rest home] from [Mrs C], Nurse Manager, (pages 9-12) including interview notes marked 'C'
> - Information supplied by [Mr and Mrs G] (pages 13-17) marked 'D'
> - Information supplied by the Nursing Council of New Zealand and Ministry of Health (pages 18-20) marked 'E'
> - Information supplied by Disability Support Link (pages 21-22) marked 'F'
> - Information supplied by [Dr D] (pages 23-25) marked 'G'
> - Information from [Dr E] (pages 26-35) marked 'H'

- Information supplied by [Mrs F] including telephone interview notes (pages 36-43) marked 'I'
- Information from [the geriatric hospital] (pages 43-76) marked 'J'
- [Miss B's] medical records from [the rest home] (pages 77-103) marked 'K'
- [Miss B's] medical records from [the public hospital] (pages 104-140) marked 'L'
- Job description for Registered Nurse at [the rest home]

Literature and other documents reviewed during this report

- 'The importance of patients' nutritional status in wound healing' (British Journal of Nursing, 2001, (Supplement) Vol 10, No 6) by Linda Russell (Tissue Viability Nurse Specialist, Queen's Hospital, Burtons Hospitals, NHS Trust, Belvedere Road, Burton on Trent, England)
- Ministry of Health Contract 2002
- Code of Conduct for Nurses and Midwives January 1995 by the Nursing Council of New Zealand
- Employment of enrolled nurses within acute settings by Karen O Poutasi (Dr), Director-General of Health and Marion Clark, Chief Executive Officer, Nursing Council of New Zealand; released by the Ministry of Health

What particular standards apply in this case?

The standards that apply in this case are that relating to Registered Nurses, who must abide by the Nursing Council of New Zealand's Code of Conduct for Nurses and Midwives 1995. Care delivered to a Respite Care Resident must also meet the Ministry of Health Contract standards by both the Registered Nurse and the Manager.

It must be noted here that the Nurse Manager is an Enrolled Nurse and as such, must work under the direction and supervision of either a Medical Practitioner or a Registered Nurse under section 53A of the Nurses Act 1977 (Employment of enrolled nurses within acute settings by Karen O Poutasi (Dr), Director-General of Health and Marion Clark, Chief Executive Officer, Nursing Council of New Zealand).

Did the care provided by [the rest home] meet those standards and, if not, how was the care deficient?

It is evident that the care giving staff have delivered appropriate care to [Miss B] during her stay, and had reported the wound status to the Nurse Manager verbally and through the nursing progress notes, but appear to have lacked appropriate backup and supervision from the Nurse Manager.

In my opinion, the care delivered by the Registered Nurse and Nurse Manager to [Miss B] was inadequate and did not meet the standards of the Nursing Council's Code of Conduct for Nurses and Midwives 1995, the Ministry of Health Contract or section 53A of the Nurses Act 1977.

[Miss B] was admitted on the 22 July 2002. The Nurse Manager documented an 'Assessment' for [Miss B], dated 27 July 2002; this appears to be a combination of some assessment and care plan and is inadequate and late in my opinion. Although [Miss B] was admitted as a respite Resident and was awaiting urgent assessment by the Disability Support Link for care at [the rest home], her initial assessment and care plan should have been conducted and documented within 24 hours of admission, with a full care plan within 3 weeks, as per the Ministry of Health Contract for subsidised Residents. It is essential that thorough assessments of [Miss B's] skin, wound, pain and continence as well as a thorough nursing assessment should have been done, and comprehensive care plans developed to reflect the assessed needs, despite the fact that [Miss B] was at [the rest home] on respite; as her health status required thorough assessment and plan development. There is no evidence that a full care plan was developed within the 3 weeks or that the assessment 'care plan' was reviewed in relation to the changing health status of [Miss B] and her heel ulcers, wound assessment of the hip ulcers as they developed or a wound care plan commenced and documented. A wound care plan should have been commenced showing the dressings required, the re-evaluations and subsequent dressing changes. The Registered Nurse should have done the assessments and care plans with input from the Nurse Manager and caregivers.

The Ministry of Health Contract 2002 for subsidised Residents under clause D17 d ii states: *The role of the Manager includes, but is not limited to, ensuring the Subsidised Residents of the Home are adequately cared for in respect of their every day needs. Under clause D17 e You must employ, contract or otherwise engage at least one Registered Nurse, excluding a registered psychiatric nurse, who will be responsible for working with staff and (where that Registered Nurse is not the Manager) the Manager to:*

i. assess Subsidised Residents:
   1 on admission;
   2 when the Subsidised Resident's health status changes;
   3 when the Subsidised Resident's level of dependency changes
ii. develop and/or review Care Plans in consultation with the Subsidised Resident and family/whanau;
iv. provide and supervise care;
v. act as a resource person and fulfil an education role;
vi. monitor the competence of other nursing and Care Staff to ensure safe practice

The Registered Nurse in her letter to the Commissioner dated 17 December 2003 reported that she only relieved four hours per day at weekends and diligently followed instructions either written or verbal from the Nurse Manager as to special needs of Residents, but that in unusual or emergency situations, she used her initiative. She also mentioned that it was customary for the Nurse Manager to institute patient care plans at the time of admission. During the phone call between [the investigation officer] (HDC) and [Mrs F] on the 13/01/2004, [Mrs F] informed [HDC] when asked, that she did not have oversight of the Nurse Manager, Mrs C. [Mrs F] also mentioned in the phone call that she was a Public Health Nurse at [the public hospital] and had started working at [the rest home] to help [Mrs G] out.

Although the Ministry of Health Contract 2002 is for Subsidised Residents and [Miss B] was an unassessed respite Resident at the time, in my opinion, the Nurse Manager and Registered Nurse should have been meeting the standards expected in the Ministry of Health Contract in relation to [Miss B]. In my opinion, I believe that both the Nurse Manager and the Registered Nurse appear to have no knowledge of their contractual requirements or that of their nursing registration requirements in relation to the Nursing Act of 1977 and the Nursing Council's Code of Conduct for Nurses and Midwives 1995.

It would be expected practice to call in the advice of a wound nurse specialist to assist the Rest Home staff with wound management in difficult or non-responding wounds to current treatment. The Nurse Manager stated in her letter to [Miss A] dated 13 November 2002: *I want to thank you for informing me about the wound resource nurse as I did not know of this service*. The Registered Nurse stated in her letter to the Commissioner dated 17 December 2003: *Re: Wound Resource Nurse: I was unaware this nurse was available to residential care homes*. In my opinion, either the Nurse Manager or the Registered Nurse could have contacted [the public hospital] or District Nursing Services to find out if such a service was available.

In [Mrs F's] (the Registered Nurse) letter in response to the Commissioner dated 17 December 2003, [Mrs F] states that she: *was employed to work weekends only, doing four hours duty on both Saturday and Sunday. I agreed to do 'call' over these weekends* ***if asked*** *when the Nurse Manager was not available. When on duty I always inspect and do all dressings as required ... according to dressing notes left, or in problem cases after telephone discussion with the nurse manager or medical staff. I worked under instruction from the Nurse Manager and was only on duty a total of 4-8 hours each weekend. [Miss B] had been admitted five days before I first met her and the nursing care plan was in place.*

[Mrs F] has documented in the progress notes when she dressed [Miss B's] wounds and at times commented on the appearance of the wounds and their oozing through bandages and dressing products used. In my opinion, [Mrs F] did not document as fully as she should, given the continual suppuration of the wounds, nor is there any evidence that she discussed the wounds with the Nurse Manager or a Medical Practitioner.

It is the responsibility of the Registered Nurse, in this case [Mrs F], to deliver appropriate and reasonable wound care, using skill and professional knowledge, to the Resident and to advise the Nurse Manager in the appropriate wound care or to obtain further advice from a wound care specialist. Accurate, ongoing assessment, thorough documentation and appropriate multidisciplinary referrals to ensure that the Resident's condition was assessed and treated appropriately and to the highest standard is the expected outcome from a Registered Nurse delivering professional, quality care.

[Mrs C], Nurse Manager, should have taken the responsibility of dressing [Miss B's] wounds herself on her workdays rather than the care giving staff, and document[ed] the wound and dressings used. I note in [Dr E's] letter to the Commissioner dated

10/12/2003 that he reviewed [Miss B's] heel ulcers with [Mrs C] and the Plastics Registrar at [the public hospital], and that he stated: *As to the hip lesions ... I was unaware of their existence during her stay at [the rest home]. [Miss B], her relatives or the staff at [the rest home], did not bring them to my attention*. I believe that [Mrs C] should have requested the General Practitioner to assess the hip ulcers and discuss wound management. As an Enrolled Nurse, [Mrs C] should have ensured that she worked under the direction of the Medical Practitioner and Registered Nurse.

Should [Miss B] have had medical assistance and treatment to ulcers on her feet sooner?

In my opinion, the General Practitioner should have reviewed [Miss B's] heel ulcers earlier. [The rest home] was also able to access the expertise of the Wound Resource Nurse from [the public hospital] for specialist advice pertaining to the heel and hip ulcers and the appropriate care and dressings required. I note that [Miss B] was admitted dehydrated and clearly in a frail state of health. [The rest home] had documented her thin fragile skin, indicating a propensity for skin tears and breakdown. Her blood albumin was low during her admission to [the public hospital] and had dropped lower during her stay at [the rest home] (on the 23/08/02 blood test) indicating poor nutritional intake, this would have affected her ability to heal the ulcers and fight an infection. On admission, the Nurse Manager had documented that [Miss B] was of normal weight for her height, there is no documentation supporting this claim, and the fact that [Miss B] was placed on a food and fluid intake chart indicates concern re her oral intake. There is no evidence of a weight on admission nor any subsequent weights, also there was no evidence of reassessment or evaluation of [Miss B's] food and fluid intake. There is no evidence of dietician involvement in this Resident, which would have been appropriate nutritional care and would have assisted with wound healing

Should [the rest home] have sought a prescription for antibiotics for [Miss B] sooner?

In my opinion, [the rest home] was slow at seeking a medical opinion on whether a prescription for antibiotics for the heel ulcers was warranted in the first instance and then obtaining a review for more antibiotics. On the 7/08/02, the ulcers were weeping blood, this in itself does not necessarily indicate infection although it would be quite likely that the ulcers were infected, however it would have been prudent for the ulcers to have been reviewed at this point, swabs taken to rule out infection and appropriate dressings used to manage the ulcers. The nursing progress notes for the 14/08/02 indicate swabs of the ulcers were taken for a suspected infection and that antibiotics were commenced, there is an administration record sheet, which shows antibiotics were given for 1 week. There is no record in [Dr D's] notes that he prescribed these antibiotics, he comments, '[the rest home] phoned, has infected pressure sores which are being treated with intrasite gel at present. Swabs have been taken.' [Miss B] was then transferred to the care of [Dr E], following which there is no mention of follow up of the wound swabs, the possible infection which could have been resistant to the antibiotic prescribed. [Dr E] does not document knowledge that the wounds were suspected as being infected by [the rest home] prior to him taking over [Miss B's] care, that swabs had been taken and antibiotics charted in advance of knowing whether there

was an infection and what organism was responsible. Four weeks later [Dr E] did review the heel ulcers and commence further antibiotics, on the 11/09/02, following a swab result and a discussion with the Plastics Registrar (6/9/02).

In relation to the hip ulcers, the nursing progress notes state: *Strong stench noticed Duoderm on R) hip had rolled down*. (?/9/02); *Strong smell came from her dressing* (?/10/02); *[Miss B's] R) hip oozing under duoderm. Reported to N/M*. (?/10/02); (*R) side hip seeping fluid, some redness and warm to touch* (?/10/02); these reports indicate there may be an infection to the ulcers. [The geriatric hospital] and Rest Home Charge Nurse, […], in her letter to [the rest home] dated 31 October 2002 stated: *There was evidence of Staph Aureus and Pseudomonas infection in the left foot, right heel and hip ulcers, which required treatment with antibiotics*.

In my opinion, [the rest home] were negligent at not obtaining medical assessment for the strong possibility that antibiotics were required for the hip ulcers and the heel ulcers during the later part of September and early October (Note, I was unable to determine the exact dates due to the poor photocopying for the above paragraph).

Should [the rest home] have sought medical assessment and treatment when [Miss B] developed ulcers on her hips?

In my opinion, [the rest home's] Registered Nurse and Nurse Manager were negligent in not requesting medical assessment and treatment for [Miss B's] hip ulcers. It is clear that [Miss B] developed the hip ulcers during her stay at [the rest home] and there was no medical assessment sought. [Dr E] stated in his letter to the Commissioner dated 10/12/2003 about [Miss B's] foot ulcers: *I telephoned the Plastics Registrar at [the public hospital] about [Miss B] …. He further advised that admission to hospital would not be appropriate at that time but to send a referral to Plastics Clinic.* In the same letter [Dr E] states: *As to the hip lesions [Miss B] had on her transfer to [the geriatric hospital], I was unaware of their existence during her stay at [the rest home]*. As [Dr E] had documented in his medical progress notes on the 11/9/02 that he had contacted the Plastics Registrar for advice about the heel ulcers, both the Registered Nurse and the Nurse Manager must have known he had phoned and that clearly [Dr E] would have sought advice from the Plastics Registrar for the hip ulcers if he had been aware of them and the extent of their breakdown, suppuration and lack of response to the dressings used.

[Mrs F] had not documented a thorough wound assessment or wound care plan, which is expected practice from a Registered Nurse, although she did document in the progress notes. [Mrs F] could also have sought the assistance of the Wound Resource Nurse from [the public hospital] to assist her with an appropriate wound care plan and appropriate wound dressing products, or could have requested [Mrs C], the Nurse Manager, to contact the Wound Resource Nurse for her. Even if [Mrs F] or [Mrs C] did not know there was a Wound Resource Nurse available, they would have soon been able to resource the information by ringing the District Nursing Service [at the public hospital] or the GP and ask if there was a service available to them. As [Mrs F] worked during the week for [the public hospital] as a Public Nurse, I believe she would also

have had opportunities to enquire through colleagues or [the public hospital]. It is clearly documented from the Registered Nurse and care giving staff that the hips were oozing through the dressings and at times had a very strong smell to them as well as her urine, this was reported to the Nurse Manager through the nursing progress notes and verbally from a caregiver on the 2nd or 3rd of October (exact date difficult to tell because of the poor photocopying). There is no documented evidence that the Registered Nurse sought input from the General Practitioner or recommended the Nurse Manager to do so during the weekdays on her behalf.

There is no evidence of any follow up to the Registered Nurse and care-giving staff reports in the nursing progress notes from the Nurse Manager. There is no documentation in the nursing progress notes written by the Nurse Manager following that date until the date of discharge, 16/10/02, despite the fact that the care giving staff documented on the 11/10/02 that 'Dressings done by [Mrs C] – no problems', the Nurse Manager had clearly redressed the wounds and had not documented this herself. From the documentation by the care giving staff, it is clear that the care giving staff were dressing the wounds on a regular basis, documenting the odour and weeping from the ulcers with little input from the Nurse Manager with no wound care plan to follow.

On the 16 October, [Miss B] was transferred to [the geriatric hospital] and Rest Home. [The geriatric hospital] Charge Nurse, […], wrote a letter, dated 31 October 2002, to [Mrs C] ([the rest home's] Nurse Manager) stating that on admission to the geriatric hospital: *We were shocked on examining [Miss B] shortly after admission to find a very large, full thickness pressure ulcer on her right hip measuring 9cm x 7cm and so deep it was down to the hip ligaments at one end. The other hip had a necrotic area measuring 6cm x 5cm with surrounding redness indicative of severe tissue damage. These required a referral to […] (wound resource nurse) from [the public hospital] to seek advice on the appropriate dressings and management.*

In my opinion, the Registered Nurse failed to assess the wounds appropriately and on an ongoing basis and document her reassessments and wound care plan, and failed to seek appropriate medical and wound specialist advice. In my opinion, the Nurse Manager also failed to seek appropriate medical and wound specialist advice. I also believe that with extensive ulcers, as described by [the geriatric hospital] Charge Nurse, these would have been very painful for [Miss B]; [Miss B] would not have been able to clearly express her pain levels due to her Dementia and confusion (see [the public hospital's] Discharge Summary). In my opinion, both the Nurse Manager and Registered Nurse should also have assessed [Miss B's] pain level using a pain assessment tool, taking into account her Dementia and confusion, and sought medical input for appropriate pain management.

Any other matter which, in your opinion, should be brought to the Commissioner's attention.

Disability Support Link

In my opinion, [Miss B's] condition as described by the care giving staff in the nursing progress notes indicates that [Miss B's] care needs levels were higher than Rest Home

level. I note that [Dr D] sent an urgent referral for assessment to the Disability Support Link service on the 22/07/02 and was received by Disability Support Link on the 23/07/02 as described in their letter dated 15 September 2003. Disability Support Link documented in their letter that on the 16/08/02, [Miss B] *was upgraded to SNL 5 following Disability Support Link generated review* and was then *moved to [the geriatric hospital] level care.* In my opinion, this wait of 3 weeks and 3 days is an unacceptable timeframe from the urgent referral sent by [Dr D]. In my opinion, Disability Support Link service should have reassessed [Miss B] as soon as possible and within 2 or 3 days. Likewise, [the rest home] should have pursued the referral earlier, not only from a caring perspective, but also from the funding perspective.

[Dr E]
In my opinion, although it was the responsibility of [the rest home's] Registered Nurse (or Nurse Manager during the weekdays on behalf of the Registered Nurse) to inform their GP about the hip ulcers, it would have been best practice for the GP, [Dr E] to fully medically assess [Miss B] in view of her failing health, her inability to communicate her needs and the ongoing difficulties with the heel ulcers. If he had fully assessed [Miss B], he would have seen the hip ulcers and been able to give medical treatment in a timely fashion.

Dietician Assessment
In my opinion, due to [Miss B's] low albumin and her pressure areas (as mentioned previously), [the rest home's] Registered Nurse should have requested the Nurse Manager to instigate a Dietician assessment for [Miss B]. I believe that [Dr E] should also have instigated a Dietician assessment for [Miss B]. Linda Russell (Tissue Viability Nurse Specialist, Queen's Hospital, Burtons Hospitals, NHS Trust, Belvedere Road, Burton on Trent, England) wrote 'The importance of patients' nutritional status in wound healing' (British Journal of Nursing, 2001, (Supplement) Vol 10, No 6). She states, '*High exudate loss can result in a deficit of as much as 100g of protein in one day. This subsequently needs to be replaced with a high protein diet.*' She also goes on to say, '*There is a correlation between low serum albumin* (protein) *and body mass index (BMI) and the development of pressure ulcers …. Holistic assessment of nutrition and early detection of malnutrition are essential to promote effective wound healing.*'

[The rest home] Governance
There appears to be a system failure and lack of information from [the rest home] Governance to the Nurse Manager about her responsibilities in meeting the Ministry of Health Contract and in ensuring that the Nurse Manager receives the Disability Support Link Resident assessments. In view of [Mrs C's] mentioning to [HDC investigation officer] that she did not receive the Disability Support Link assessments, I question whether [Mrs C] had access to a copy of the Ministry of Health Contract.

Upon reading the job description (supplied by [HDC] on my request), which apparently [Mrs C] was expected to work within; I note that this job description is that of a Registered Nurse responsible to the Manager and not that of a Rest Home Manager/Enrolled Nurse. In my opinion, this job description does not outline a Rest

Home Manager's responsibilities accurately and is not applicable or appropriate to [Mrs C's] position.

In my opinion, [the rest home] Governance warrants further investigation in relation to the apparent system failure, apparent lack of orientation and support offered to [Mrs C], the inappropriate job description and also the apparent lack of policies and procedures, namely; Complaints Policy and Procedure, Continence Management Policy, Declining Entry Policy, Exit/Discharge/Transfer Policy, Nursing Care Plan Policy, Pain Management Policy, Referral Policy, Skin Management Policy and Wound Management Policy; these should have been available to the Nurse Manager, [Mrs C].

In my opinion, [the rest home] Governance warrant further investigation in relation to the misunderstandings of on-call work, the apparent lack of a job description on employment, the apparent misunderstanding by the Registered Nurse in her responsibilities, apparent lack of education and the apparent lack of policies and procedures (as named in the above point) which should have been available to her.

Nurse Manager

In my opinion, [Mrs C] wrote a transfer letter which did not indicate to [the geriatric hospital] and Rest Home the severity of [Miss B's] heel and hip ulcers appropriately and in fact when written to by [the geriatric hospital] and Rest Home Charge Nurse indicating their concerns over the poor condition of [Miss B] and her ulcers, [Mrs C] defended herself by citing lack of orientation and her difficulties in overseeing [the rest home]. In my opinion, this does not alter the fact that [Mrs C], as an Enrolled Nurse, must practise within the bounds of Section 53A of the Nurses Act 1977, the Code of Conduct for Nurses and Midwives 1995 and the Ministry of Health Contract Manager requirements, which she failed to do so.

In my opinion, [Mrs C] failed to meet her responsibilities as an Enrolled Nurse, who must practise within the bounds of the Code of Conduct for Nurses and Midwives 1995 and Section 53A of the Nurses Act 1977, and failed to meet her responsibilities as a Manager under the Ministry of Health Contract. [Mrs C] did not inform the General Practitioner of the development of the hip ulcers nor ask him to assess them and assist with a management plan. [Mrs C] also did not request either the Registered Nurse or the General Practitioner to assess [Miss B] for pain and a pain management plan, which given the extent of the hip ulcers, [Miss B] must have been in pain. [Mrs C] did not ensure that the Registered Nurse formally assess [Miss B] and develop the care plans as per the Ministry of Health Contract. In the Ministry of Health Contract, the Manager is required to:

D17.5
b. You shall ensure all staff who will be in direct contact with the Subsidised Residents have completed education that is related to the care of older people.

D17.6
a. Any Registered Nurse or health professional carrying out a delegated medical task or a specialised procedure or treatment must have demonstrated prior competency in the

task, procedure or treatment, and follow documented policies, and protocols developed by the facility to ensure safe practice.

In my opinion, the Nurse Manager apparently failed to organise or ensure that she had access to education for the Registered Nurse, particularly in view of [Miss B's] difficult wounds and the MOH Contract requirements for demonstrated prior competency.

I believe that [Mrs C] was in breach of the Code of Conduct for Nurses and Midwives, Principle Two (2.3, 2.4, 2.5, 2.7, 2.9); Principle Three (3.6); Principle Four (4.3, 4.4, 4.6). Again, I believe that [Mrs C] did not provide care to [Miss B], which met professional standards using knowledge, skill and reasonable care required by an Enrolled Nurse; this would incur moderate disapproval from peers.

Registered Nurse

It appears that [Mrs F] was unaware of her responsibilities under the Ministry of Health Contract and that she did not receive a job description at the time of her employment with [the rest home] (the Registered Nurse states in her letter dated 17 December 2003: *I enclose a copy of a job description given to me on 6/11/02*). There also appears to be a discrepancy about the on call work that the Registered Nurse was supposed to be doing. The Registered Nurse stated in her letter dated 17 December 2003 *I was employed to work weekends only. I agreed to do 'call' over these weekends if asked when the Nurse Manager was not available.* In the telephone conversation with [the HDC investigation officer] on the 13/01/2004 [Mrs F] stated in answer to the question was she ever on call during the week: *no, she was employed by Mrs G and made that very clear to them that she would not be on call*. The Nurse Manager informed [the HDC investigation officer] during the interview on the 12 November 2003 that *the Registered Nurse is on call during the week*. [Mr G] (Director) for [the rest home] stated in his letter dated 10th October 2003: *we then employed a Registered Nurse who was on call during the weekdays and public holidays and on duty on the weekends.*

It is evident from the Registered Nurse's educational record that [Mrs F] had received training related to Public Health but no formal training in Aged Care. Under D17.2 e of the Ministry of Health Contract, the Registered Nurse is required to:

iv. provide and supervise care
v. act as a resource person and fulfil an education role
vi. monitor the competence of other nursing and Care Staff to ensure safe practice
vii. advise management of the staff's training needs

D17.6
a. Any Registered Nurse or health professional carrying out a delegated medical task or a specialised procedure or treatment must have demonstrated prior competency in the task, procedure or treatment, and follow documented policies, and protocols developed by the facility to ensure safe practice.

I believe it would be difficult for [Mrs F] to meet these requirements with the lack of education in Aged Care and an apparent lack of policy and procedure. Also, [Mrs F]

had no current formal training in wound management and thus could not demonstrate competency.

I would expect all Registered Nurses to be able to comprehensively assess clients and develop appropriate nursing care plans. If [the rest home's] Registered Nurse was not able to conduct assessments and develop nursing care plans, [the rest home] would need to implement training for the Registered Nurse and provide adequate support and supervision for her.

In my opinion, [Mrs F] failed to meet her responsibilities as a Registered Nurse, who must practise within the bounds of the Code of Conduct for Nurses and Midwives 1995, Section 53A of the Nurses Act 1977 and the Ministry of Health Contract Registered Nurse requirements. [Mrs F] did not conduct and record regular assessments of [Miss B] for all aspects of her care, nor did she develop and/or review her care plans in consultation with [Miss B's] sister, as required by the Ministry of Health Contract for subsidised Residents (as stated earlier, I believe that respite Residents' care should be up to the standard for subsidised Residents). It is apparent from [Mrs F's] comments that she worked under the direction of the Nurse Manager [and] that she did not have oversight of [Mrs C], Nurse Manager and Enrolled Nurse.

I believe that [Mrs F] was in breach of the Code of Conduct for Nurses and Midwives, Principle Two (2.4, 2.5, 2.7, 2.9); Principle Three (3.6); Principle Four (4.3, 4.4, 4.6). Again, I believe that [Mrs F] did not provide care to [Miss B], which met professional standards using knowledge, skill and reasonable care required by a Registered Nurse; this would incur moderate disapproval from peers.

In conclusion, whilst both the Nurse Manager and the Registered Nurse were remiss and did not discharge their responsibilities to [Miss B], abide by their limitations of practice, and in the case of the Registered Nurse have oversight of the Nurse Manager (Enrolled Nurse), I believe there were factors which affected their ability to do so. There appeared to be misunderstandings and lack of information in relation to their roles; good Governance with clear appropriate job descriptions and by ensuring that both the Nurse Manager and Registered Nurse had full access to all relevant information, such as the Ministry of Health Contract and the Disability Support Link assessments for Residents, could have prevented this. This does not, however, negate the lack of responsibility and professionalism displayed by both the Nurse Manager and Registered Nurse in relation to the hip ulcers and pain management. Prompt response by Disability Support Link to an urgent referral for assessment in a timely fashion may also have affected the outcome; like[wise] had a full medical assessment been undertaken by the General Practitioner, this may also have affected the outcome for [Miss B]. Involvement of a Dietician and a wound specialist in [Miss B's] care would also have resulted in a better outcome for [Miss B]. In effect, [Miss B] who suffered from Dementia and an inability to express herself clearly suffered from the extensive hip ulcers, which would have caused her considerable pain and discomfort and was denied appropriate treatment in a timely fashion."

Responses to Provisional Opinion

Miss A
Miss A advised me that the purpose of making the complaint was because the rest home refused to have a doctor visit Miss B. When he did visit her he was never shown the ulcers on her hips, which the geriatric hospital described to her as "deep and serious". She did not know about the ulcers on her sister's hips.

Mrs C
Mrs C advised me that she has worked hard at reviewing, changing, and developing policies and procedures to improve the standards of care at the rest home. She has found that outside help is available and how to obtain it. She was not aware of this previously. She has also discovered courses that she and her registered nurse can attend and take by correspondence. Reviews are being undertaken by the health and safety team to improve care at the rest home.

Mrs F
A legal advisor responded to my provisional opinion on behalf of Mrs F, as follows:

> "We write to provide submissions regarding the Provisional Opinion provided to [Mrs F]. Initially we will deal with some factual issues and then turn to particular sections of the Provisional Opinion. There is some overlap between material in different sections, but any comment on an issue in one place should be taken to refer to that issue when covered in other sections.
>
> **[Mrs F's] employment**
> [Mrs F] only worked a total of 8 hours during the weekend. She is clear that her on-call availability was only for weekend specially arranged when the Manager [Mrs C], was to be away.
>
> **Employment Agreement/Job Description**
> Although [Mrs F] previously described the unsigned Individual Employment Agreement as a job description (in her letter of 17 December 2003), it is clear that it is not a job description. In fact the definitions of types of employment at the bottom of the first page do not even cover the nursing role.
>
> She advises that she was not given anything else which could be described as a Job Description.
>
> **Supervision of [Mrs C]**
> [Mrs F] was not told (either verbally or in writing) that supervising the Nurse Manager [Mrs C] was part of her job. In any event it was almost impossible for [Mrs F] to supervise [Mrs C] given that:
> (a) She never worked at the same time as [Mrs C];
> (b) [Mrs C] was her boss; and
> (c) [Mrs C] had more relevant experience in terms of aged care expertise and wound care management than [Mrs F].

In our submission it is thus not reasonable to impose on [Mrs F] any obligation to have supervised [Mrs C].

In any event [Mrs F] was not aware of any deficiencies in [Mrs C's] practice.

Ministry of Health Contract
Ms Jenny Baker considers that [Mrs F] should have been meeting the standards expected in the Ministry of Health contract. Reference is made to the Nurse Manager and Registered Nurse having 'no knowledge of their contractual requirement ...' (top of page 16).

Without in any way accepting that [Mrs F] did not meet those standards, in our submission it is not reasonable to require her to do so. The Ministry of Health contract is at best a contract between the provider organisation ([the rest home]) and the Ministry. [Mrs F] is not a party to that contract. Her employer never provided her a copy of the contract or even brought it to her attention.

We also strongly object to such wide, speculative and unsubstantiated statements as 'the Nurse Manager and the Registered Nurse appear to have no knowledge ... of their nursing registration requirements in relation to the Nurses Act of 1977 and the Nursing Council's Code of Conduct for Nurses and Midwives 1995' (first paragraph page 16).

[Dr E]
[Mrs F] was aware that [Dr E] was seeing [Miss B] for her ulcers. She quite reasonably assumed that this was for the hip ulcers as well as the foot ulcers.

Thus she thought that [Miss B's] ulcers were receiving proper medical assessment and treatment. Therefore there was nothing more which she felt she needed to do on that front. With the GP involved already, the GP could have ensured that [Miss B] received any additional assistance or indeed hospitalisation for her ulcers if that was assessed as being necessary by the doctor.

As a GP, [Dr E] would not usually have been available to be contacted or visiting [Miss B] at the times which [Mrs F] worked, namely the weekends.

'Should [the rest home] have sought* a *prescription for antibiotics ... sooner?'

The advisor concludes that '[the rest home] were negligent in not obtaining medical assessment for the strong possibility that antibiotics were required for the hip ulcers and the heel ulcers during the later part of September and early October …' (page 18).

However, that view is clearly not sustainable on the evidence. Firstly, [Miss B] was prescribed antibiotics by Dr D on 14 August. [Dr E] commenced [Miss B] on a 14 day course of antibiotics from 11 September. [Dr E] also saw [Miss B] on 25 September. It appears that he may have chosen not to repeat the prescription but that is his issue and cannot be laid at the feet of [the rest home's] staff. See pages 7 and 8 of the Provisional Opinion for this information.

'Should [the rest home] have sought medical assessment and treatment when [Miss B] developed ulcers on her hips?'

The advisor's opinion is that the Registered Nurse and Nurse Manager were negligent in not requesting medical assessment and treatment of [Miss B's] hip ulcer.

[Mrs F] was not present when [Dr E] visited [Miss B] as she did not work during the week. She thought quite reasonably that [Dr E] had been made aware of the hip ulcers. She in fact did check with [Mrs C] that [Dr E] was involved with treating the hip ulcers (see her letter 16 June 2004).

In our submission it was thus not unreasonable for [Mrs F] to believe that [Dr E] was providing medical assessment and treatment on the hip ulcers. She should thus not be considered negligent for failing to take further action in that regard.

[Mrs F's] ability to seek further medical assessment for [Miss B] was severely limited by the fact she only worked during the weekends.

The advisor suggests that [Mrs F] and [Mrs C] could have obtained information on the Wound Care Nurse at [the public hospital] by ringing the District Nursing Service, Hospital, or the GP (bottom of page 18). However, this is clearly circular. Neither of them knew that such a service was available and thus they would not have been phoning anyone to check on the availability of such a service. It is suggested that they could have phoned the GP and asked, but the evidence is that the GP [Dr E] was not aware of this service either (page 8 Provisional Opinion). The fact that the GP was not aware of this service may suggest that it was a new one.

[Dr E] did discuss [Miss B's] case with a Plastics Registrar, however, there is not indication that the registrar suggested the involvement of the Wound Care Nurse either.

The suggestion is made that [Mrs F] could have enquired from [the public hospital] when she was working as a public health nurse about services available. However, as she has stated [her] work was in the community and at schools.

'Opinion: Breach – [Mrs F]' (page 28-9 Provisional Opinion)

…

Section 53A of the Nurses Act does not place an obligation on registered nurses to direct and supervise enrolled nurses in clinical matters. What it does is make it an offence for enrolled nurses to practise other than under the supervision of a registered nurse or a medical practitioner.

It may well be correct that from a general point of view [Mrs F] had more nursing knowledge than [Mrs C]. However, [Mrs C] appears to have had more knowledge in terms of wound care (and aged care work generally).

Given [Dr E's] involvement it could well be seen that he was directing and supervising [Mrs C] on clinical matters relating to [Miss B].

It is suggested that [Mrs F], if working outside her area of knowledge should have sought appropriate expertise. However, there is evidence that [Miss B] had input from people of appropriate expertise. [Mrs C] had wound care and aged care experience. [Miss B] was seen by [Dr E] the GP in terms of her ulcers. He in turn spoke to a Plastics Registrar from [the public hospital]. He arranged an appointment for [Miss B] at the Plastics Clinic. Although [Mrs F] may not have caused these things to happen she was aware that they had happened and that impacts on the necessity for her to do anything further. Also, towards the end she did question [Mrs C] as to whether [Miss B] should be at [the rest home] and whether she needed to be in hospital.

In our submission [Mrs F] did deliver 'appropriate and reasonable wound care in keeping with [Miss B's] needs' (page 28 Provisional Opinion). There appears to be nothing in the advice provided to [the] Commissioner as to alternative wound care which [Miss B] did not have but should have (such as different dressings or the like). [Mrs F] did regularly assess [Miss B's] ulcers and thoroughly documented the care she provided in the Progress Notes.

Reference is made to seeking a dietary assessment for [Miss B]. However, as [Mrs F] says in her letter of 16 June 2004, in her experience [Miss B] ate well, and on only one occasion did she see her not eating. We also note that [Miss B] was already on Vitamin C and zinc dietary supplements, both of which are of use for skin and healing.

The Provisional Opinion states that in working in an area in which she had no experience [Mrs F] breached Rights 4(2) of the Code of Rights.

However, [the] Nursing Council currently does not have restrictions requiring people only to work within a particular scope of practice or the like. This will be a requirement under the Health Practitioners Competence Assurance Act, but those provisions are not in force as yet.

All practitioners will have to work in at least one area in which they have no experience, otherwise they will never be able to get any experience. Also for those who want to change their area of practice they will also have to start working in an area in which they have no experience. It should not be considered unprofessional or in breach of the Code simply to work in such an area.

The Provisional Opinion states that [Mrs F] was 'out of date with current trends in wound management', and yet there is no indication that we can see from the expert advisor's opinion of any evidence to substantiate this. What trends are being referred to? On what basis is the advisor (or the Commissioner) able to form a view as to whether [Mrs F] was or was not up to date with these trends? Given that the advisor does not seem to state any actual clinical treatments which should have been done differently or not done at all, it is difficult to see any basis for this finding.

It is suggested that [Mrs F] could have recommended to [Mrs C] that she consult other health professionals about [Miss B's] ulcer management. However, as note[d] above, [Mrs C] did consult another health professional, namely initially [Dr D] then [Dr E]. In turn [Dr E] consulted the Plastics Registrar at the Hospital and an appointment was requested for [Miss B] to go to the Plastics Clinic. [Mrs F] was aware of this. In such circumstances it was not unreasonable for [Mrs F] to consider that it was unnecessary to request further medical input.

The Provisional Opinion refers to [Mrs F] not fulfilling 'her contractual obligations', thus breaching Right 4(2) (top of page 29). It is not clear what contractual obligation is referred to. It appears it may be to the Ministry of Health contract. As stated above, [Mrs F] is not a party to the contract between [the rest home] and the Ministry of Health (and did not even have a copy of it). Thus it should not be suggested that she was in breach of her contractual obligations.

In conclusion we submit that in the particular circumstances of this case, [Mrs F] did provide services with a reasonable standard of care and skill."

In addition to the legal advisor's response, Mrs F provided the following response to my provisional opinion:

"[**Miss B] – [the rest home]**

I am writing in response to the Commissioner's Provisional Opinion. There are a number of points which I wish to dispute or provide more information on.

…

[Miss B's] ulcers

I believe that I appropriately assessed and treated [Miss B's] ulcers, given the limited time I worked, and the fact it was on the weekends.

I regularly assessed and redressed the heel ulcers.

[Mrs C] covered the hip ulcers in duoderm and ordered that they not be disturbed. Thus I did not often see those ulcers. There were about three occasions when I redid the hip dressings, when the bandage had come off etc.

My clear recollection is that for most of the period [Miss B] was at [the rest home] the areas which I could see around the hip dressings were not red or inflamed looking. The exception to this was shortly before [Miss B] was moved, when on 6 October I documented that the skin around the right hip looked red.

On 13th October I documented the right hip as being 'not so red around the edges, but still suppurating'. The left hip was drier and less inflamed.

I remember their size as being approx. 4cm by 7 cm, oval in shape.

I saw no sign of necrosis at this time.

I was aware that [Dr E] was seeing [Miss B], but these visits occurred during the week when I was not present. As far as I knew [Dr E] was aware of [Miss B's] hip ulcers and was overseeing the treatment of them. As I recall I checked with [Mrs C], probably on the occasions when I actually saw the hip ulcers, whether the doctor had seen the hip wounds and was treating them. She said he was and we were doing our best with them.

Obviously the courses of antibiotics prescribed by [Dr D] and [Dr E] would have affected the hip area as well as the heels.

I was aware that [Dr E] had consulted the Hospital about [Miss B's] ulcers, and that she was to have an appointment with the Plastics Clinic at the Hospital. Given that these things were in train it seemed that [Miss B] was receiving the appropriate medical input in terms of her ulcers.

At one point, perhaps in October 2002, having dressed [Miss B's] hip, I said to [Mrs C] shouldn't [Miss B] be in a hospital, [Mrs C] said that [Miss B] was still at the same grade and was in respite care.

It has been suggested that I could have asked at the Hospital through my public health nurse work. However, the public health nurses are based at the Community Health Unit and my work there is community and schools based.

I am not aware of any deficiencies in [Mrs C's] knowledge or practice. As far as I was aware she was appropriately reporting to [Dr E] and liaising with him on [Miss B's] care.

Pain

[Miss B] was charted and received Panadol Q I D [four times daily] for most of her time at [the rest home]. At no time did [Miss B] complain of pain to me.

Care Plans

I did not fill out care plans. That was [Mrs C's] job (page 5 of Provisional Opinion). As I recall care plans started to be implemented in the lead up to or during the audit process.

Nutrition

[Miss B] did not have nutrition problems during most of her time at [the rest home]. She had meals in the dining room and fed herself. I often heard her express enjoyment in the meals she ate. Towards the end of her time at [the rest home] I saw on one occasion that she did not eat a meal that had been provided to her in bed. However, that was not enough to lead me to think a dietitian's assistance was needed.

Mobility

I ensured that caregivers (and myself on occasions) assisted [Miss B] to mobilise."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Professional standards

Section 53A of the Nurses Act 1977 states:

"Every enrolled nurse commits an offence and is liable on summary conviction to a fine not exceeding $1,000 who, other than in an emergency, practises nursing other than under the direction and supervision of a registered nurse or medical practitioner."

The Nursing Council of New Zealand *Code of Conduct for Nurses and Midwives* (1999 update) states:

"Principle Two: The nurse or midwife acts ethically and maintains standards of practice:

Criteria

…

2.3 is accountable for practising safely within her/his scope of practice;

2.4 demonstrates expected competencies in the practice are in which they are currently engaged;

2.5 upholds established standards of professional nursing or midwifery practice;

2.7 maintains and updates professional knowledge and skills on area of practice;

2.9 accurately maintains required records related to nursing or midwifery practice.

Principle Three: The nurse or midwife respects the rights of patients/clients.

Criteria

…

3.6 is aware of and guided by codes of rights and responsibilities for patient/clients and healthcare providers in area of practice …

Principle Four: Justifies public trust and confidence

…

4.3 uses professional knowledge and skills to promote patient/client safety and wellbeing;

4.4 reports to an appropriate person or authority any limitations in professional expertise or personal health status or circumstances which could jeopardise patient/client safety;

…

4.6 takes care that a professional act or omission does not have an adverse effect on the safety or wellbeing of patients/clients."

The Nursing Council's *Enrolled Nurse Education Framework* (November 2001) defines the scope of an enrolled nurse as follows:

"Enrolled nurses work with people across the lifespan with predictable health outcomes in situations that do not call for complex nursing judgements, in health promotion, disease prevention and care of the sick."

The Nursing Council's *Standards for Enrolment of Nurses* (September 1992) state:

"Role of the Enrolled Nurse

The enrolled nurse implements nursing care for designated people under the guidance and direction of the registered nurse. This should not be a task orientated approach. The programme leading to enrolment prepares the nurse to care for people who have relatively stable and predictable health outcomes, to maintain and safeguard comfort and dignity, to promote health and safety."

Opinion: No breach – Dr D

Under Right 4(1) of the Code Miss B had the right to medical services provided with reasonable care and skill.

The district nurse called Dr D about Miss B on 22 July and he arrived promptly. He did not perform a complete medical assessment but recognised that Miss A could no longer care for her sister and arranged her admission to the rest home. He also arranged for DSL to assess Miss B urgently with a view to a permanent placement. Dr D did not hear again from the rest home until 14 August, when he was informed that Miss B's wounds were infected. He prescribed antibiotics. At some stage Dr D telephoned Dr E (whether in response to a telephone call from Miss A or Mrs C is not important). As a result he telephoned Dr E, who he assumed was caring for Miss B, because he had been asked to pass on Miss A's concerns.

After a careful review of all the information, I am satisfied that Dr D provided Miss B with reasonable care and skill, and therefore did not breach Right 4(1) of the Code.

Opinion: No breach – Dr E

My advisor said that it would have been best practice for Dr E to undertake a complete assessment of Miss B. Had he done so, he would have found the ulcers on her hips. Mrs C said that if Dr E had read the nursing notes he would have noted that Miss B was developing ulcers on her hips.

In my view Dr E should have been able to rely on the nursing staff, in particular the nurse manager, to bring Miss B's deterioration to his attention. A complete medical assessment and full examination may have been best practice, but Dr E not unreasonably relied on nursing staff to bring specific concerns to his attention. Very little about the hip ulcers was recorded in Miss B's nursing notes, and so Dr E was not alerted to the problem.

Dr E's responsibility, according to the Ministry of Health contract, was to perform three-monthly reviews, and any other reviews for problems brought to his attention. Dr E reviewed Miss B's heels at each visit, commenced antibiotics, consulted the plastics registrar at the public hospital, and arranged a referral to the outpatients clinic to have her heels assessed. It seems that he would have provided the same services if he had known about Miss B's hips.

In my opinion Dr E provided services with reasonable care and skill, and therefore did not breach Right 4(1) of the Code.

Opinion: No breach – Mrs F

Mrs F is a registered nurse, required to practise in accordance with the Nurses Act 1977 and the Nursing Council's *Code of Conduct*. Mrs F was employed at the rest home for four hours a day each Saturday and Sunday to allow the manager, enrolled nurse Mrs C, days off. Mrs F supervised the carers and changed dressings. If she found any problems she would report them to Mrs C on Monday.

My advisor stated that, as the registered nurse at the rest home, Mrs F had more nursing knowledge that Mrs C, an enrolled nurse. From a legal viewpoint Mrs F's responsibility was to use her knowledge and skill to promote Miss B's safety. If she was practising outside of her knowledge, she had a responsibility to recognise that fact and seek appropriate expertise. Mrs F had a responsibility to deliver appropriate and reasonable wound care in keeping with Miss B's needs, which required regular re-assessment of her circulation and state of the ulcers. Accurate, ongoing assessment, thorough documentation and appropriate multi-disciplinary referrals would have helped ensure that Miss B was treated appropriately.

My advisor was critical of Mrs F's care, noting that she failed to document her wound assessment or wound care plan. My advisor considered this contrary to the expected practice of a registered nurse. Mrs F failed to assess the wounds appropriately and on an ongoing basis, and to document her reassessments and wound care plan. She failed to seek appropriate medical and wound specialist advice. She should have asked the manager to obtain a dietary assessment for Miss B.

In my advisor's opinion Mrs F was practising in aged care with no experience or training in the field. When changing Miss B's dressing she simply followed Mrs C's instructions. It was a case of the "blind leading the blind". Mrs F abdicated her registered nurse responsibilities, to the detriment of the quality of nursing care Miss B was entitled to receive.

My nursing advisor considered that, as a registered nurse, Mrs F was under an obligation to supervise Mrs C, citing section 53A of the Nurses Act. However, section 53A places no obligation on registered nurses to supervise enrolled nurses. The provision makes it illegal for enrolled nurses to practise without the supervision of a registered nurse or doctor. Mrs C was effectively under the supervision of Dr E.

It would in any event have been very difficult for Mrs F to supervise Mrs C. They did not work together and, although Mrs F may have had more general nursing knowledge, Mrs C was more experienced in care of the elderly and wound management. Mrs C was Mrs F's "boss", and Mrs F did not have direct access to Dr E as medical rounds were conducted by Mrs C, who also documented the nursing care plans.

I have obtained records from the rest home that document Mrs F's ulcer assessment on Miss B's heels. There is very little information about her hips. Miss B's hips were covered with Duoderm when redness first appeared. Mrs C instructed that the Duoderm was to be

left on, and Mrs F did not dress Miss B's hips until just before her transfer to the geriatric hospital Hospital.

I agree that Mrs F should have undertaken and documented a more detailed assessment of Miss B's wounds. I share my advisor's concerns that Mrs F may not properly have recognised her registered nurse responsibilities, to the detriment of the nursing care Miss B received. However, given the limited capacity in which Mrs F worked at the rest home, it would be unreasonable to hold her to the standard set by my expert advisor – that of a full-time registered nurse. In my view Mrs F's nursing care at weekends was adequate, and in the circumstances did not breach Right 4(1) of the Code.

Opinion: Breach – Mrs C

Mrs C was employed as a manager at the rest home but she also fulfilled a nursing role. Her nursing responsibilities included identifying residents' needs and ensuring that the rest home was capable of meeting them. She was required to provide care plans for each resident so that carers knew what was to be done to meet their needs; implement systems to ensure the availability of appropriately skilled staff; and seek a medical review and multi-disciplinary intervention where necessary.

As an enrolled nurse, Mrs C was bound by the Nurses Act 1977 (the Act) and the Nursing Council's Code of Conduct. As noted above, section 53A of the Act placed limitations on her nursing practice. She was required to practise under the direction and supervision of a registered nurse or medical practitioner. Under the Council's *Code of Conduct* Mrs C had an ethical duty to maintain her professional standards, use her knowledge to promote patient safety, respect the rights of patients, and justify public trust and confidence in her practice. Mrs C could provide nursing care for patients who have "relatively stable and predictable health outcomes".

Miss B was admitted for respite care initially. She was assessed three days later and it was agreed between the assessor and Miss A that Miss B was suitable for long-term rest home care. Mrs C's status as an enrolled nurse enabled her to work with residents such as Miss B while she remained relatively stable.

My advisor identified a number of areas where Mrs C's performance did not reach these standards, as discussed below.

Although Mrs C assessed Miss B's skin, wounds, pain and continence levels in the first three days of her admission, she did not complete a comprehensive care plan to reflect the assessed needs, which she should have done irrespective of Miss B's respite care status. The assessment and care plans should have been documented and changed as Miss B's health status altered. There is also no evidence that a full care plan was developed during the time of her admission or that the care plans were reviewed regularly in relation to Miss B's changing health status. Proper assessment and documentation of her heel and hip

ulcers, a wound care plan indicating the type and frequency of dressings required, and evaluation of the effectiveness of treatment, were all absent.

Mrs C should have requested that Dr E assess Miss B's hip ulcers and review her wound management and need for antibiotics. No medical assessment was sought for Miss B's hips throughout her stay. In failing to bring Miss B's hips ulcers to Dr E's attention, Mrs C was not acting within section 53A of the Nurses Act 1977. Mrs C was also slow to seek a medical opinion on whether antibiotics should be prescribed for Miss B's heel ulcers.

My advisor said that Mrs C did not ensure that Miss B received appropriate nutritional care. On some occasions Miss B ate well but at other times she refused food. Mrs C prescribed dietary supplements, Vitamin C and zinc, but did not consult a dietician as Miss B deteriorated. Inadequate nutrition would have impacted on Miss B's ability to heal.

It is clear that Miss B's nursing needs were complex and required planned, consistent nursing management and would have benefited from input from a specialist in wound management. Mrs C did not meet the standards expected of an enrolled nurse, or the managerial responsibilities outlined in her job description. In my view she was simply overwhelmed by her new position and the impending Ministry of Health Audit.

Miss B was entitled to nursing care that responded appropriately to her deterioration. Mrs C did not recognise the limitations of her position and should have sought help sooner. Miss B needed to go to a hospital where her wounds could be appropriately assessed and treated. In the circumstances, Mrs C failed to provide nursing services with reasonable care and skill, in compliance with legal and professional standards, and therefore breached Right 4(1) and 4(2) of the Code.

Opinion: Breach – The Foundation

Direct liability

The Foundation, as owners and licensees of the rest home, is a health care provider bound by the Code of Health and Disability Services Consumers' Rights, and was subject to a duty to provide Miss B with services with reasonable care and skill.

Mrs C was employed by the Foundation as a manager. It is clear from the Ministry of Health audit that the Foundation did not have appropriate systems in place to ensure an appropriate standard of nursing care. Its responsibility to Miss B was to ensure that she received appropriate care, including appropriate care of her ulcers, in an environment that ensured her safety with appropriately skilled and experienced staff who could adequately assess and treat her ulcers.

The Foundation appointed Mrs C because she was the best candidate, with many years of experience as an enrolled nurse. The job description the Foundation used to identify the manager's role was inappropriate. It is a job description for a registered nurse responsible to the manager and does not outline a rest home manager's responsibilities accurately. It

was not appropriate for Mrs C's position. It called for Mrs C to, amongst other things, write policies and put in place systems for co-ordinating care planning and procedures for safe medication practice, and to monitor health intervention to ensure client goals are achieved. In real terms Mrs C was expected to be one of the clinical nurses with hands-on involvement in nursing care planning, ongoing assessment and evaluation, rest home administration and planning, and staffing matters such as ongoing development, performance review etc. She was also required to prepare for a Ministry of Health audit within five months of commencing the job.

My advisor was critical of the Foundation employing Mrs C, stating that she should have been supervised by a registered nurse in her nursing practice. As noted above, this is an incorrect interpretation of section 53A of the Nurses Act 1977. Mrs C should have practised under the supervision of a registered nurse or doctor. Some of Mrs C's nursing practice was supervised by Dr E.

To help Mrs C familiarise herself with the system requirements of the job the Foundation sent Mrs G, a director of the Foundation with no background in nursing, to provide two weeks' orientation. The Foundation employed a registered nurse for eight hours a week at a time when Mrs C was not working. Furthermore, the registered nurse was a public health nurse, a position that does not demand individual care planning or knowledge of complex wound interventions. The registered nurse understood that she would be filling in for Mrs C, complying with her orders and on call when she required the weekend off.

Mrs C's management responsibilities included providing and supervising care; acting as a resource person and fulfilling an education role; monitoring the competence of other nursing and care staff to ensure safe practice; and advising management of the staff's training needs.

In summary, Mrs C worked as a nurse and the manager but was employed as a manager. In addition to her nursing responsibilities, Mrs C was also expected to fulfil her management role and prepare for the Ministry of Health audit. It was unfair of the Foundation to expect Mrs C to fulfil all the duties expected of her. In my opinion the Foundation should have ensured that Mrs C was appropriately skilled and experienced, and had sufficient support, for all aspects of the role for which it employed her. Mrs C was set up to fail, and this placed the safety of residents at the rest home at risk. In the circumstances, the Foundation failed to exercise reasonable care and skill and breached Right 4(1) of the Code.

Vicarious liability

In addition to any direct liability for a breach of the Code, employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for any employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

Mrs C was employed by the Foundation. In failing to reassess and respond appropriately to Miss B's deterioration, Mrs C demonstrated a lack of clinical skills. As an enrolled nurse, Mrs C was not competent to take on a nurse manager's position. Mrs C was not qualified to

provide unsupervised level five geriatric nursing care. Eight hours a week of registered nurse time did not meet the shortfall. Neither Mr nor Mrs G had any nursing knowledge and could not have known whether the residents at the rest home were receiving quality nursing care. In these circumstances the Foundation is vicariously liable for Mrs C's breach of the Code.

Actions taken

- Mrs C has apologised to Miss A for breaching the Code and has reviewed her practice in light of this report.
- The Foundation has apologised to Miss A for breaching the Code and the apology has been forwarded to Miss A. The Foundation has reviewed its policies and practice in light of this report.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand and the Ministry of Health.
- A copy of this report, with details identifying the parties removed, will be sent to the Nursing Council of New Zealand, and Residential Care NZ Inc, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.