A Rest Home

Registered Nurse, Ms C

General Practitioner, Dr D

A Report by the

Health and Disability Commissioner

(Case 04HDC08400)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mr B	Provider/Manager and licensee, Rest Home
Ms C	Provider/Registered nurse
Dr D	Provider/General practitioner
Mrs E	Complainant/Consumer's daughter
Dr F	General Practitioner

Complaint

On 12 November 2003, the Commissioner received a complaint from a Health and Disability Advocacy Service about the services provided to a number of residents at a rest home. Information was obtained, and in May 2004 the Commissioner decided to investigate the care provided to Mrs A. The following issues were identified for investigation:

The Rest Home
Whether the rest home appropriately managed Mrs A's care between 1 November 2002 until her transfer to a nursing home on 8 April 2003. In particular:

- *whether the pressure area care provided to Mrs A was adequate and appropriate;*
- *whether there was appropriate response to Mrs A's deteriorating condition;*
- *whether Mrs A's pain was appropriately managed.*

Ms C
On 21 September 2004, the Commissioner extended the investigation to include the role of registered nurse Ms C in relation to each of these issues.

Dr D
On 12 November 2004, the Commissioner extended the investigation to include Dr D, general practitioner, and the following issues:

Whether Dr D appropriately managed Mrs A, resident of the rest home, from December 2002 to March 2003. In particular:

- *the adequacy and appropriateness of treatment prescribed for Mrs A's deteriorating pressure areas.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information reviewed

Information from:
- The rest home
- Ms C
- Mrs E
- Dr D
- The Nursing Home
- Ministry of Health (audit report 30 August 2004).

Independent expert advice was obtained from Mr Stephen Neville, registered nurse.

Information gathered during investigation

Background

The rest home
In December 2002, the rest home was a 30-bed rest home, managed and owned by Mr B, a registered comprehensive nurse.

Ms C
The clinical care provided to the residents of the rest home was planned and assessed by Ms C, who had worked there for 16 years. Ms C qualified in 1974, and is registered as a psychiatric nurse with the Nursing Council of New Zealand. Her job description (revised in August 2002) described her overall responsibilities at the rest home. These included:

"• Coordinating with medical, social-agencies, families and those involved with residents' health and well being.
- Attending doctor's rounds and visits and following through with orders and new medication.
- Keeping, maintaining and updating all resident and personal care plans. …
- Staff education and on going training."

Mr B stated that Ms C was the person who had primary responsibility for the planning and assessment of Mrs A's care.

Dr D
Although there was no written agreement for medical services in place at the time of Mrs A's residency at the rest home, Dr D was the registered general practitioner for the majority of the residents. Dr D commenced work at the local medical centre in September 2002, where he worked as a single-handed practitioner.

Mrs A
Mrs A was admitted to the rest home on 3 October 2001, and in November 2002 was aged 94 years. The admission documentation describes Mrs A as requiring considerable assistance with her activities of daily living, including two staff to assist with her hygiene needs, dressing, and mobility. In respect of her sleep pattern, the admission assessment stated "sleeps quite well, wakes for pain". From the time of her admission, Mrs A had required dressings for sores on her left leg, which by 11 November 2002 were considered to have healed. The progress notes record that Mrs A showed occasional signs of confusion, particularly at night. There had also been some concerns raised over the condition of her pressure areas.[1]

Chronology of events

November 2002 to April 2003
On 1 November, Mrs A's progress notes recorded that she had a small pressure sore on her back, to which paraffin gauze and dressings were applied. Further references to Mrs A's pressure areas were made in subsequent progress notes, with Ms C requesting on 7 November that the night staff ensure that Mrs A was "put on her side at night" because her "bottom [was] quite sore". On 16 November, Mrs A's right heel required dressing and was described as "very sore", and the progress notes requested that the night staff turn Mrs A regularly at night and offer fluids.

On 22 November, a specific wound-care plan was commenced for pressure sores that were developing on Mrs A's right heel and bottom. The instructions were to "apply zinc and cast[o]r oil and gauze". This care plan continued until 12 January 2003.

On 26 November and 1 December, Ms C recorded in the progress notes that she had redressed Mrs A's heel. On 4 December, Ms C recorded "Foot redressed still very raw". The following day, Dr D visited and entered the following in the notes:

> "Pressure sore on heel.
> [On examination] right heel inflamed and tender and infection."

Dr D prescribed a course of antibiotics (Augmentin) to treat Mrs A's infection.

[1] For example: 12 February 2002 ("getting a sore bottom"); 14 February 2002 ("Has a couple of little blisters on her bottom"); 19 February 2002 ("Aqueous cream applied to sore bottom"); 20 March 2002 ("Pressure sore on heel dressed with Paranet non-stick [dressing] and gauze"); 3 August 2002 ("Redressed both legs and bottom").

Ms C recorded on 10 December that a pressure sore was starting to develop on Mrs A's left hip, and advised the staff that Mrs A "Must be turned at night".

On 19 December, Mrs A's heel was re-dressed. Ms C noted that the sore on Mrs A's hip required dressing with Paranet and Combine. On 29 December, the sore was described as "green and brown".

Ms C changed Mrs A's foot and hip dressings on 30 December, but made no reference to the condition of the wounds in the care plan or the progress notes. Mrs A was reviewed by Dr D, who referred to an infected lesion on her upper lip. He commenced a further course of antibiotics, and recorded "?Skin cancer — [basal cell carcinoma]". There is no reference in the clinical records to Dr D having reviewed Mrs A's pressure areas.

On 8 January 2003, Ms C recorded that Mrs A's right hip was starting to look sore, and stated that she was not getting turned often enough. On 11 January, the progress notes recorded "Raw area on bottom rubbed with zinc and castor oil".

A wound-care plan was commenced on 12 January for the pressure areas on Mrs A's heel and right hip, and remained in use until 8 February.

On 14 January, Ms C recorded in the progress notes that signs of pressure were starting on Mrs A's right hip and shoulder. On 20 January, Mrs A's right hip was also "showing signs of breaking down".

Mrs A was reviewed by Dr D on 22 January. He commenced antibiotics (Augmentin) for the infected pressure sore on Mrs A 's left hip, and instructed that a swab be taken.

The following day a wound-care plan was commenced for dressing Mrs A's left hip. This remained in place until 14 February. The plan instructed:

> "Clean [with] saline, apply zinc and castor oil to edge of wound, place microfibre dressing into wound, cover with [non-stick dressing] and gamgee."

Ms C recorded on 26 January that the sore on Mrs A's left hip was looking cleaner. On 29 January, Dr D also recorded that this sore appeared to have improved.

On 13 February 2003, Ms C recorded that she re-dressed Mrs A's sore on her left hip with Convatex, and dressed Mrs A's right hip with Silvazine and gauze. On 27 February, Ms C put povidone iodine paste into the sore on Mrs A's left hip.

Ms C recorded on 3 March that the sore on Mrs A's hip was "starting to decrease in size". There is no reference to whether this was the sore on her left hip or her right hip.

On 5 March, a specific wound-care plan was completed for "left hip, ulcer, heel, right hip". This plan remained in place until 7 April. The instructions were:

> "Left hip: Daily clean with saline apply Povo paste put 555 cream around it and cover with non stick dressing.
> Heel: Apply Povo paste apply non stick dressing and bandage.
> Right hip: Clean with saline, apply 555 around it and apply Silvazine on it, non stick dressing.
> Bottom: Clean with saline apply paranet and non stick."

Ms C stated that these dressings were prescribed by Dr D.

Ms C recorded on 10 March, "Dressings re-done — not looking the best". Four days later, the pressure sore on Mrs A's right hip was noted to have increased in size.

Mrs A required analgesia "regularly" on 15 March, and the following day Ms C observed that Mrs A's physical condition was deteriorating.

On 19 March, Dr D reviewed Mrs A. He noted her pressure sores. There is no indication in Dr D's medical record that the sores, or Mrs A's general condition, had deteriorated, although he noted that Mrs A did have "oedema of lower legs + feet + perineum + hips". His plan was to order physiotherapy for Mrs A and await the results of the wound swab prior to commencing antibiotics. Dr D stated:

> "When I last saw [Mrs A] on [19 March] her pressure sores on both heels and her left hip were quite minor albeit infected hence my taking of swabs and commencement of antibiotic treatment on that day."

Dr D was not involved in Mrs A's care after this date because at the end of March the provider of medical services to residents of the rest home was changed to an alternative medical practice. According to Mr B, the reason for the change was that the alternative practice "is a multi-GP practice rather than a single practitioner".

On 20 March, Ms C recorded in the progress notes that Mrs A was to have Panadol four times a day. It is unclear whether this plan was made in consultation with a doctor or other staff. The following day Mrs A was noted to have chest pain, and on 22 March she was described as "feeling rotten".

On 24 March, Ms C recorded that Mrs A's pressure sores were re-dressed, and "still not looking good". On 27 March, the sore on Mrs A's left hip was "getting worse". Ms C stated:

> "I would have informed [Mr B] of the situation, as it appears by the notes that I must have had the following days off. By reading the notes, in my absence I can only assume nothing was done, until I asked [Dr F] to call on the 1 April 2003."

Ms C was at work on 30 and 31 March, and signed Mrs A's care plan to state that she had attended to the dressings on those days. There is no reference to the condition of Mrs A's pressure sores in the progress notes for 30 and 31 March.

On 1 April, at Ms C's request, Mrs A was reviewed by Dr F, general practitioner (to whose care Mrs A had been transferred). Dr F requested a review by the district nursing team, who attended two days later and changed the dressings used to Aquacele and Duoderm.

On 4 April, the team leader of a Community Support Group [2] wrote to Mr B:

> "[The Community Support Group] has been concerned to receive a report from the District Nurses expressing concern about [Mrs A's] significant pressure areas that have developed recently.
>
> The District Nurses are of the opinion that [Mrs A] needs a higher level of nursing care than she is able to receive currently.
>
> As discussed with you, [the Community Support Group] will be reassessing with a view to authorising hospital level care with a facility that is able to provide this level of care. We are concerned that no referral from [the rest home] has been received by us to perform a reassessment, as her needs appear to have changed significantly."

On 8 April, Mrs A was transferred to a nursing home for hospital-level care. Her pressure sores were assessed on arrival:

> "Transferred from [the rest home] at 14.00hrs.
>
> We were informed dressings had not been changed and needed to be. Offensive smell noted on admission. Following pressure areas dressed:
>
> 1. Left hip: deep full thickness with cavity … area approx 40–50mm in diameter. Purulent exudates.
> 2. Left buttock: pressure area 30–40mm approx. in diameter, sloughy and offensive exudates.
> 3. Right hip: large pressure area approx 100mm — 2 areas of necrotic tissue plus small red area below 2 necrotic areas …
> 4. Left lower leg: small sloughy ulcer approx 15–20mm.
> 5. Left heel: small sloughy pressure area approx 5–10mm in diameter.
> 6. Right leg: lower, several small abrasions with mild bruising.
>
> Photos taken of all pressure areas."

[2] Community Support Group: Department of Community Health and Disability Services, a DHB.

The general practitioner responsible for the residents of the nursing home reviewed Mrs A on 9 April 2003. He recorded that she had multiple serious pressure areas on her pelvis and lower limbs, and noted, "I have never experienced such severe pressure areas in my career as a GP."

Mrs A's condition gradually deteriorated at the nursing home, where she died.

Specific issues

Wound care
Ms C advised that the dressings used for Mrs A "were the only dressings available to me and [Dr D] agreed that they were satisfactory". Ms C stated that she did not seek the advice of any other professional in treating Mrs A's pressure sores.

Dr D stated:

> "I … attended to [Mrs A] on 13 occasions between 12 September 2002 and 19 March 2003 for a variety of reasons mainly reviewing medications, anxiety after a fall, Parkinson's [disease] symptoms and her pressure sores.
>
> …
>
> These pressure sores were not severe, however despite trying a number of different dressings … there still was an occasional infection which I treated with antibiotics — in fact swabs were taken on at least three occasions … and antibiotics were prescribed on seven occasions.
>
> …
>
> Any doubt about the adequacy of the nursing treatment that I might have had was alleviated by the fact that [the rest home] passed at least one Ministry of Health audit, maybe two, whilst I was looking after the patients there, so I accepted the occurrence of pressure sores as a fact of the severity of the patients' conditions and the fact that [the rest home] according to the manager [Mr B] has to get by with so little funding.
>
> …
>
> A GP looking after a nursing home obviously has to rely on the matron to … raise concerns about patients and if [Mrs A] has not responded to the treatment prescribed on 19 March 2003 [then] the onus of follow-up or change of treatment is on the caregivers and the nurses to report back to the GP.
>
> I did not consider a district nurse referral for a number of reasons. Firstly … [Mrs A's] pressure sores were not that bad until 19 March 2003, secondly she obviously was a resident in a nursing home and district nurses primarily visit patients living in the community — a suggestion to involve district nurses would have been perceived as a vote of no confidence to [Ms C] …"

Pain management
Ms C stated that Mrs A was prescribed regular analgesia, and that staff were instructed "to observe [Mrs A's] body language and ask if she required extra pain relief". Ms C considered that Mrs A's "constant" calling out was not pain-related. Ms C stated:

> "When asked on numerous occasions why [Mrs A] was making this noise … she would reply that she didn't know she was doing it and then laugh."

The analgesia prescribed in April 2003 was the same as that prescribed on Mrs A's admission to the rest home in October 2001: Vioxx 25mg daily and Paradex[3] two tablets, twice a day.

The care plan relating to Mrs A's pain control had been reviewed by Ms C on 13 May and 28 October 2002. The first review stated that Mrs A "will ask for pain relief", and the latter review confirmed that assessment. A further document, "Ongoing Assessment and Care Review" has been provided to my Office by the rest home. This refers to three reviews by [Ms C] of [Mrs A's] care: on 10 July 2002, 16 January 2003 and 10 March 2003. On the last review, Ms C recorded "Will say [if she is in pain] — watch body language".

According to the progress notes, from 1 November 2002 until 13 March 2003, pain relief was given to Mrs A on two occasions: 13 and 21 December 2002. From 13 March 2003, analgesia is recorded as having been given on 13, 14, 15, 20, 21 and 22 March.

During March 2003, on all but six days[4] there are references in the progress notes to Mrs A being agitated or calling out. The comments below are from the progress notes:

"
- 14 March: 'very vocal when moved';
- 17 March: 'not a happy lady — keeps calling out all day';
- 26 March: 'calls out every time you turn her';
- 28 March: 'called out just about every time I turned her'."

Training
Ms C described the training that she had received while at the rest home as follows:

> "The only formal training I received at [the rest home] for the period 2002–2003 was 'Care and management of people with dementia'. … As for the other three topics ie wound care, pressure area care, care planning and documentation, courses or seminars were never offered to me by [Mr B]. I tried to keep up to date by reading nursing [journals], books and talking to other nurses.
>
> In regards to the question of training and education of staff, I orientated staff to the routine cares of — toileting, washing, showering, dressing, feeding, making beds,

[3] Paradex: Medicine containing in each tablet 325mg paracetamol combined with 50mg dextropropoxyphene napsylate.
[4] 11, 15, 19, 23, 25, 27 March 2003.

> pressure area care, giving and recording of medication, reporting and documenting, all this was done to the best of my knowledge ability and experience. Incontinence was dealt with by incontinence product educators as an in-service."

Mr B stated:

> "[Ms C] was a registered nurse with many years experience in rest home care, particularly dementia care. She kept her skills and knowledge up to date with new procedures through monthly Journals, and advisors from [the public hospital] would update and give in-services as to the best procedures for all areas of clinical procedures, particularly wound care and prevention and treatment of pressure areas.
>
> Unfortunately, at this time, we did not hold an exact record of training provided to staff and the dates when training was given and cannot provide exact details of this training."

Ms C stated:

> "[Mr B's] comments on advice from [the public hospital] on in-service and clinical procedures, just didn't happen. I asked him on more than one occasion why we never got notice of inservice programs from the hospital — he said he didn't know."

The rest home policies

Pressure area management protocol
The rest home provided a copy of its "Pressure Area Management" plan, which was in place at the time of Mrs A's residency. This document, which is specific for each patient, has a place for an individual resident's name and GP, and states:

> "Residents should be assessed for risk of pressure sores by using the Revised Norton Pressure Area Scale at the time of admission, and the risk factor prominently marked on [the] care plan with required treatment. …
>
> [The] Registered Nurse has the responsibility for evaluating and devising policies for the treatment and prevention of pressure sores. Educational training on the causes, prevention and management of pressure sores shall also be the responsibility of the Registered Nurse."

A classification of pressure sores is also included, grading a sore from 1 to 4, "1" being skin discolouration, and "4" being full thickness skin ulceration and deep cavity formation.

No document has been provided during the investigation to indicate whether Mrs A was assessed using the Norton Scale. There is no record of any classification of the sores that developed, or use of the pressure area management plan for Mrs A.

Ms C stated in response to my provisional opinion:

> "We did not use the Norton Scale as [Mr B] reports. I saw the forms once then they disappeared."

Wound management policy
The rest home provided a copy of a wound management policy that Mr B states was in place during Mrs A's residency. It is not dated. The policy includes sections on wound assessment (to include an assessment of the severity of the pressure sore) and a specific wound assessment form. There is no copy of this form within Mrs A's clinical record, and there is no record of a formal assessment of her pressure sores.

The rest home also supplied a copy of a protocol for the management of pain. This document refers to Dr F, who became involved in the care of the rest home's residents in April 2003.

Actions taken by the rest home
Mr B advised that the following actions have been taken by the rest home:

> "Since [Mrs A] was transferred [to the nursing home] [the rest home] has completely revised all aspects of resident care especially in respect of record keeping and care planning. Staff are also undergoing a more structured regime of training using the ACE programme."

Independent advice to Commissioner

The following expert advice was obtained from Stephen Neville, registered nurse:

> "Professional Expert Advice — 04/08400
>
> Thank you for giving me the opportunity to review and give advice on the above case. The aim of the contents of this report to the Health and Disability Commissioner is to provide advice, as to whether in my professional opinion:
>
> – Did [the rest home] provide an appropriate standard of care to [Mrs A]?[5]
>
> ...

[5] At this point Mr Neville listed the questions asked of him by the Commissioner. As these are set out in the body of Mr Neville's report, they are not repeated here.

This report will begin with an overview of my professional qualifications and clinical experience, followed by a timeline outlining the events surrounding [Mrs A's] hospitalisation. Finally my professional opinion on the case will be provided. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, my own professional clinical experience of working with older adults, and reviewing the relevant literature on wound care.

Personal and professional profile

I am a registered comprehensive nurse, who has a Masters degree, is a Fellow of the College of Nurses Aotearoa (NZ) and has been nursing for 25 years. I am currently working as a lecturer in the School of Health Sciences, Massey University, Albany Campus, Auckland. I last worked in clinical practice as a registered nurse in an assessment, treatment and rehabilitation unit for people over the age of 65 years in 2001. My other clinical experiences include people with disabilities, acute care, operating theatre and health care of the older person. I am currently Chairperson of the College of Nurses Aotearoa (NZ) Inc. My research experience and publications are in older men's health and well-being, delirium in people over the age of 65 years, nursing and older people, the social aspects of ageing and health assessment.

Background

[Mrs A] was admitted to [the rest home] on 3 October 2001 from an acute care hospital. She was admitted for respite care after having a compression fracture of her spine. At the time of her admission she was 93 years of age and required significant assistance with most of her ADLs [activities of daily living]. In particular [Mrs A] required help from two staff members to get out of bed, experienced occasional incontinence of both bowel and bladder and needed help to shower. In addition she experienced episodes of confusion, had compromised skin integrity on her lower legs, as well as cellulitis, and was at risk for developing more pressure areas.

From November 2002 onwards [Mrs A's] skin integrity deteriorated significantly, resulting in pressure areas on both hips and on her left buttock. Her pressure areas became infected and were treated by her general practitioner ([Dr D]) at the time, who prescribed antibiotics and suggested ways to manage her impaired skin integrity. [Dr D] last saw [Mrs A] on 19th March 2003. From this time onward [Dr F] became responsible for [Mrs A's] medical care.

On 1st April 2003 [Dr F] assessed [Mrs A] and consequently referred her to the District Nursing Service for further assessment of her pressure areas. On 3rd April 2003 [Mrs A] was seen by a District Nurse who identified the presence of pressure ulcers on her hips and heels. From this date onwards the attending District Nurse took overall responsibility for managing the treatment of [Mrs A's] pressure areas.

[Mrs A] was transferred to [the nursing home] on the 8th April 2003. A thorough assessment was undertaken on admission to [the nursing home] and in particular they provided a detailed and appropriate description of [Mrs A's] pressure areas, including

photographs. An extensive nursing care plan was developed and nursing care implemented immediately.

On the 9th April 2003 [Mrs A] was assessed by [another general practitioner] who identified the following: 'Has multiple serious pressure areas on pelvis and lower limbs as documented. I have never experienced such severe pressure areas in my career as a GP.' A surgical consult was arranged for debridement. However [Mrs A's] condition deteriorated and she [later] died.[6]

...

Professional advice

The following professional advice is presented as per [questions] 1 through to 7 identified at the beginning of this report. I have commented at the end of each point on the level of severity associated with each of the actions. These are documented as mild, moderate or severe.

1. Was the choice of dressings used on [Mrs A's] pressure areas appropriate during the period from November 2002 until April 2003?

In my professional opinion I do not believe the choice of dressings [was] appropriate. The choice of dressing to be used on pressure ulcers should be determined by the patient's needs and the characteristics of the wound (Howard, Theodore & Wittig, 2003). [The rest home] has a wound assessment and management guideline. Within the guideline is a wound assessment form to be completed by the care manager ([Ms C]). There is no evidence in the documentation that the protocol was followed and the form completed. There is also no evidence of the clinical decision-making process involved in the choice of dressings used on [Mrs A's] pressure areas. However research suggests that Alginate dressings are appropriate for use on infected wounds, foam dressings when a non-adherent surface is required, hydrogel dressings have a cooling effect and ease pain ([Mrs A] experienced pain associated with her pressure areas) (see Bryant, 2000; Chapple, 2003; Howard et al., 2003). Howard et al. (2003) suggest that a gauze dressing soaked in a saline solution should be used when unsure what wound care product to utilise and/or until a wound care specialist recommends a definitive treatment. Gauze was used on [Mrs A's] wounds consistently between the period November 2002 and 23rd January 2003 when the treatment regime was changed to a hydrofibre dressing. At this time I would have used an alginate dressing because the wounds were infected and [an alginate dressing] would have been [of] more effect in aiding healing. On the 4th March 2003 a non-stick dressing was utilised on [Mrs A's] hips, heels and sacral area. The prescriber does not specify the type of non-stick dressing to be used. I surmise that the product used was either duoderm or tegaderm both of

[6] At this point, Mr Neville set out the complaint against the rest home and Ms C, as stated on page one of this report; it is not repeated here.

which are classified as transparent film dressings. Howard et al. (2003) advises transparent dressings do not absorb drainage (which was evident in [Mrs A's] wound) and should only be used on partial thickness wounds with minimal exudate. I rate these actions as a mild level of severity.

2. Please comment on the adequacy and appropriateness of the nursing care provided to [Mrs A]. Please comment specifically on the care relating to her pressure areas.

[The rest home] has pressure area management, skin integrity management, wound management guidelines/protocols, a wound assessment form and a wound care plan, but there is no evidence that these were fully followed or operationalised. However, none of these guidelines/protocols/forms are dated except for 'Skin Management/Skin Integrity — Maintenance' which is dated 5th December 2002. It is therefore unclear as to whether these were available to the Rest Home staff before that time. Contemporary gerontological nursing literature suggests that the maintenance of optimal nutrition and hydration are integral to maintaining skin integrity, and where pressure ulcers are present aid in the healing process (Eliopoulos, 2005; Miller, 2003). There is documentation available in [Mrs A's] clinical notes relating to how much she had to eat and drink but this was sporadic and did not give a comprehensive picture of nutritional status. Considering [Mrs A's] compromised health status her food and fluid intake should have been documented on a food and fluid chart. In addition documentation of [Mrs A's] weight should also have been provided. Then rest home staff would be able to more accurately monitor and adjust accordingly the patient's treatment regime. Finally, documentation at times encouraged two hourly turns/position changes to aid in preventing further pressure areas developing. This is a recommended nursing intervention. However, once again due to [Mrs A's] compromised health status it would have been beneficial to have formalised this through the utilisation of a turn/position change chart that was initialed/signed when the intervention was completed. I rate these actions as a mild level of severity.

3. As the registered nurse responsible for the management of [Mrs A's] care, did [Ms C] take adequate and appropriate actions to ensure that [Mrs A] received an acceptable standard of care? Please comment specifically on the care relating to [Mrs A's] pressure areas, and give reasons for your opinion.

[Ms C] has the overall responsibility for the provision of care provided to [Mrs A], including the delegation and supervision of any nursing care related activities to other health personnel. It was [Ms C's] full responsibility to ensure she was fully informed about [Mrs A's] health status, and in particular the status of her pressure areas. While there is evidence in the clinical notes that [Ms C] was aware of the need for pressure area care and appropriate interventions, the overall standard of documentation is poor. Documentation should cover all assessment aspects associated with [Mrs A's] physical condition, including any changes. In addition to information provided above in point 2, [Ms C] should have provided a comprehensive overview of [Mrs A's] pressure areas, including the use of photographs/diagrams; documentation related to the size, shape, level of tissue loss, exact location, colour of wound, clinical appearance, exudates,

condition of surrounding skin and wound edges and the presence of pain/discomfort. I rate these actions as moderately severe.

4. Was the documentation completed by nursing staff at [the rest home] of an adequate standard? Please comment specifically on the documentation used relating to pressure area care.

The documentation completed by the nursing staff at [the rest home] was in my opinion substandard, at times unprofessional, lacked adequate description and was difficult to follow. Careful, meticulous and appropriate documentation that gives a factual account of a client's health and well-being is integral to professional nursing practice. All nursing documentation forms the cornerstone of the clinical decision-making process and the making of professional nursing judgments (Robinson, 2002; Thompson & Dowding, 2002). In addition, comprehensive documentation provides an audit trail of the clinical decision-making processes undertaken by nursing staff that have resulted in the provision of care. This was not evident in [Mrs A's] clinical records. It is my opinion that appropriate documentation of [Mrs A's] skin integrity would have resulted in earlier detection of the deterioration in her pressure ulcers, which could have led to the deployment of a set of well planned interventions. I rate these actions as a mild level of severity.

5. Should nursing staff have taken any other actions during the period from November 2002 until March 2003 in relation to [Mrs A's] pressure area care? Please give reasons for your opinion.

Yes. Several times during the period November 2002 until March 2003 it was documented that [Mrs A] was disruptive, uncomfortable and in pain. There is evidence in the clinical notes of daily reports of [Mrs A] being unsettled at times, including calling out. However, minimal documentation related to pressure areas and comfort levels, including the presence of pain [which was] evident. [Mrs A's] disruptive outbursts, which were present on admission and well documented, may have been a consequence of her discomfort and pain. Chapple (2003) identifies pain as a subjective experience and serves as a protective mechanism. The documentation surrounding [Mrs A's] pain related mainly to the chemical control of this problem. It is my opinion that addressing the underlying causes of her pain is as important as providing pain relief. Finding the underlying cause also will determine the most appropriate type of analgesia to be prescribed, if any. A comprehensive pain assessment tool should have been utilised, as well as ongoing monitoring of [Mrs A's] pain [which] should have been documented. Addressing this issue is the responsibility of [Ms C]. I rate these actions as a mild level of severity.

6. What resources are available to a registered nurse in a rest home to obtain guidance on the choice of pressure area care, specifically open sores?

Many rest homes have limited resources available for supporting registered nurses in all areas of professional development, including wound management. It is unknown in this

case whether [the rest home] provided any professional development opportunities to their nursing staff. Also it is unknown what the same institution makes available in terms of wound care products. It is widely known throughout New Zealand that there are financial restrictions by Rest Home owners/managers on the type of wound care products to be purchased. However, it remains the registered nurse's full responsibility to ensure that competence to practice in the area of older person's health is maintained. In my opinion it was [Ms C's] professional responsibility to ensure she had the necessary current knowledge and skills to be able to appropriately manage [Mrs A's] care. If [Ms C] was unsure of what she might do then the following options were open to her. [Ms C] should have used her professional nursing judgment and clinical decision-making skills to realise that another professional opinion was needed. The involvement of [Mrs A's] general practitioner, the local DHB and/or the district nursing service would have been an appropriate course of action. Furthermore, it is my opinion that all registered nurses should be affiliated with a professional nursing organisation. In New Zealand the College of Nurses Aotearoa (NZ) (CNANZ) is one such organisation that provides professional support to all aspects of the nursing community. For example, New Zealand's only Nurse Practitioner in wound care belongs to the CNANZ and would have been more than happy to have provided advice and assistance in this case. I rate these actions as moderately severe.

7. Please comment on a registered nurse's responsibility, within a rest home environment, to ensure appropriate referrals are made.

In a rest home environment the registered nurse takes overall responsibility for the health and well-being of any consumers of that service. This includes the supervision of other staff, many of whom are not registered nurses. In addition the registered nurse is responsible for referrals to other health professionals/agencies.

In a letter to the Health and Disability Commissioner dated 5 November 2004 [Ms C] identifies herself as a New Zealand Registered Psychiatric Nurse. I question the appropriateness and suitability of [Ms C's] employment. While [Ms C] is working within the scope of practice, Registered Nurse, she is working outside of the conditions that are associated with being a Registered Psychiatric Nurse. The Health Practitioners Competence Assurance Act (2003) clearly identifies that a Registered Psychiatric Nurse may only practice in mental health nursing. Finally, the Nursing Council of New Zealand (the regulatory body for nursing) clearly outlines in their 'Code of Conduct for Nurses and Midwives' that all nurses must comply with legislated requirements and that they practice within the area appropriate for the part of the register in which the nurse's name is entered. In the case of [Ms C] that would be the psychiatric part of the register. Equally, it is the employer's responsibility to ensure that all Registered Nurses working within their organisation have a current practicing certificate and are working within the conditions outlined on their certificate of registration, as identified above. This would involve knowing the regulations and conditions surrounding the employment of staff, as well as citing and keeping record of the registration details of all nurses and ensuring

these people have a current practicing certificate. I rate these actions as serious and severe.

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Stephen Neville, RN, MA(Hons), FCNA(NZ)."

Response to Provisional Opinion

The rest home
Mr B, manager of the rest home, advised that he had "read and digested the … provisional opinion … and [had] no further comments to add."

Ms C
In response to my provisional opinion, Ms C made the following submission:

"In reply to your report dated 21 November. This whole investigation and allegation has been very distressing to me as I do not consider myself guilty of negligence towards [Mrs A] and her care.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I have spent all my working life looking after people and consider myself a caring person. Unfortunately there is only so much a person can do with limited resources and a manager who only cares about profit.

When [Mrs A] first came to [the rest home] it was for respite care only, till a bed was available in a hospital setting. [Mrs E] (her daughter) knew this and agreed.

As stated [Mrs A] was 93, had a fractured vertebra and numerous other physical conditions, including poor circulation.

[The rest home] has a 13 bed residential ward and a 17 bed dementia secure wing, where [Mrs A] resided.

I recall reminding [Mr B] on several occasions that [Mrs A] should be in a hospital bed as we were not equipped to care for her needs. All [Mr B] was concerned about was the money he was receiving for her care. He also informed me that [Mrs E] was happy leaving her mother at [the rest home].

[Dr D] inherited the job of GP at [the rest home], when […] sold his business to him. Unfortunately his lack of bed side manner and impatience with the elderly especially Alzheimer's sufferers left a lot to be desired. Therefore I asked [Mr B] to change our GP to [an alternative medical practice]. That is when [Dr F] came to [the rest home], and referred [Mrs A] to the district nurses (which is the only way you can get their help). This in turn got [Mrs A] transferred to a hospital bed.

[Dr D's] comment — 'I did not consider a district nurse referral for a number of reasons, and it would have been perceived as a vote of no confidence to [Ms C]' — is not a legitimate reason for not referring a person who requires more intense treatment than is being given.

One member of the night staff started the whole sorry problem by not turning [Mrs A] as asked and not doing other duties. She had several verbal warnings plus a written warning from me but because [Mr B] never did anything about these warnings, she got away with everything.

The comment re drugs not being recorded is not true. All residents had medication signing charts, for regular medication and for P.R.N medication.

Panadol and Paradex were never given together.

We did not use the Norton Scale as [Mr B] reports. I saw the forms once then they disappeared.

[Mr B's] comments re advice from [the public hospital] on inservice and clinical procedures, just didn't happen. I asked him on more than one occasion why we never got notice of inservice programs from the hospital — he said he didn't know.

[Mr B] was a registered nurse during my employment at [the rest home]. Without his presence I would not have been able to work there.

It was all very sad what happened to [Mrs A]. Please remember she was at [the rest home] on respite care awaiting hospital bed, and was in poor physical health on arrival.

I feel I am being used as a scapegoat!"

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.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

Other relevant standards

The Old People's Home Regulations (1987) state:

"37. Obligations of a licensee and manager —

(1) Every licensee of a home shall take all reasonable steps to ensure at all times —

…

(c) That the home has an adequate procedure to assess the health needs of each resident on admission to the home, and that the home continues that assessment procedure while the resident remains in the home."

The Standards of Care for Old People's Homes (1987) state:

"Standard 2

The main task of the licensee, resident manager, and all the staff is to provide for the care and comfort of those living in the home. …

Provide a safe, competent, but flexible service for your residents. …

Standard 8

The licensee or resident manager should develop programmes of orientation and continued learning for staff. …

- *Keep your staff up to date with knowledge about caring for the elderly. Include;*

  — the ageing process

  — the needs of the elderly — physical, emotional, intellectual, social and spiritual …

- *Encourage staff to attend seminars, workshops and training courses locally, regionally and nationally."*

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

"Principle one
The nurse or midwife complies with legislated requirements.

Criteria:
…
1.3 [The nurse] practices within the area appropriate for the part(s) of the register or roll of nurses in which his/her name is entered."

The standard Ministry of Health Age Related Residential Care contract, at point D.17.2, states:

"d. Manager

i. Every Rest Home must engage a Manager who holds a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home …

e. Registered Nurse

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; and
   4. at each 6 month review date in accordance with Clause D16.4(a).

ii. develop and/or review Care Plans in consultation with the Subsidised Resident and family/whanau;

iii. advise on care and administration of medication, possible side effects and reported errors/incidents;

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;

viii. assist in the development of policies and procedures."

Opinion: Breach — Ms C

Scope of practice

As noted by Mr Steven Neville, my independent nursing advisor, the registered nurse in a rest home environment takes overall responsibility for the health and well-being of the residents of that rest home. However, Ms C is a registered psychiatric nurse, and not a registered general nurse. Ms C was working outside her scope of practice. The Code of Conduct for Nurses and Midwives (1999) stated that a nurse must practise within the area appropriate for the part of the register or roll of nurses in which his or her name is entered. As a registered psychiatric nurse, Ms C was qualified to work only in the mental health sphere. Although some residents of the rest home may have had dementia, it is also probable that a significant component of their care needs was general nursing. The question of Ms C's appropriateness to work in that environment is discussed more fully on page 23, as it raises questions about her overall suitability for employment in that role. Nonetheless, Ms C was a qualified nurse who knowingly engaged in patient care. As such, she must be accountable for her actions.

Nursing care

As the registered nurse charged with planning and assessing Mrs A's clinical care at the rest home, it was Ms C's responsibility to provide services with reasonable care and skill, in a manner consistent with Mrs A's needs, in accordance with Rights 4(1) and (3) of the Code of Health and Disability Services Consumers' Rights (the Code). My expert identified many areas of poor nursing care. For the reasons set out below, in my opinion Ms C breached the Code when caring for Mrs A.

Mrs A was an elderly lady of 93 when she was first admitted to the rest home. She required considerable care and assistance with daily activities and, as such, can be described as vulnerable. My expert questioned whether Mrs A received adequate food and fluids. In his view, Mrs A's condition warranted a record of her nutritional and fluid intake, but this did not occur. Similarly, Mrs A does not appear to have been weighed and, therefore, it would have been difficult for staff to provide basic monitoring of her condition. Without such monitoring, staff were hampered in their ability to adjust their care according to her needs.

Mrs A's condition did deteriorate when she began to develop pressure sores. From February 2002, staff recorded intermittent comments about Mrs A's reddened bottom, and in August it was recorded that she required dressings to both legs and her bottom. In November a wound-care plan was commenced and in December a pressure sore began to develop on Mrs A's left hip. Mrs A's skin condition continued to deteriorate. By March 2003, the wound-care plan covered her left hip, ulcer, heel and right hip.

One way to minimise the occurrence of pressure areas is to regularly turn patients to relieve pressure on bony prominences. The records show that instructions were given for Mrs A to be regularly turned, but my expert stated that it would have been better to record the turns by use of a turn chart.

Although Ms C did treat Mrs A's pressure areas and leave instructions for staff at the rest home to dress her pressure sores, her treatment regime was inadequate. Inappropriate dressings were used, particularly once the wounds became infected. In addition, my expert commented that Mrs C did not adequately review Mrs A's pressure areas and failed to document the "size, shape, level of tissue loss, exact location, colour of wound, clinical appearance, exudates, condition of surrounding skin and wound edges and the presence of pain/discomfort".

The "Pressure Area Management" plan that was in use at the time of Mrs A's residency at the rest home required staff to use the Norton Scale to assess the level of risk of a resident developing pressure sores. There is no evidence that an assessment using the Norton Scale, or any other risk measurement system, was used to plan Mrs A's pressure area care.

In planning Mrs A's care, Ms C also needed to ensure that Mrs A received appropriate analgesia. Ms C stated that she believed that Mrs A's "constant calling out [as documented in her notes] was not … pain related". Ms C suggested that Mrs A was unaware she was calling out or making noise at times. However, as Mrs A's condition deteriorated in March 2003, staff increasingly observed her calling out. In my view, there was a definite causal link

between Mrs A's position being altered and her calling out. She was obviously in pain. In addition, taking into account the description of the pressure sores as recorded by staff at the nursing home, it is hard to believe Ms C's claim that Mrs A was not suffering significant pain.

Ms C wrote on the care plan that staff should be aware of Mrs A's body language when assessing her pain. As Mrs A exhibited signs of pain (calling out when moved) in the latter part of March 2003, that should have indicated to Ms C and her staff that there was a need to review Mrs A's pain management plan. There is no evidence that the need to review analgesia was brought to Dr D's attention by Ms C; the analgesia remained unchanged and seemingly unreviewed from October 2001 until April 2003.

I am concerned by Ms C's advice on 20 March 2003 that Mrs A should be given "Panadol x 4 a day". At best, this advice was ambiguous; at worst, unsafe. There is no indication of the dosage required, or the time at which the drug was to be administered, and no indication that there had been a change in the pain management plan. In addition, there is no record that the Panadol had been prescribed by a doctor, or evidence that an increased analgesic requirement had been communicated to Mrs A's doctor. By administering to Mrs A Paradex and Panadol together, there was also the possibility that she would receive an unacceptably high dose of paracetamol, a constituent of both drugs.

Mr Neville stated that a comprehensive pain assessment tool should have been used to help find the underlying cause of the pain, and Mrs A's pain should have been monitored and assessed on an ongoing basis.

Deterioration in condition

Dr D last reviewed Mrs A on 19 March 2003. The next time she was medically reviewed was by Dr F on 1 April 2003, just under two weeks later. The clinical record shows that Mrs A's condition was deteriorating during this period. Ms C failed to respond appropriately to this.

On 21 March, Mrs A was recorded as having had chest pain, and on the following day she was described as "feeling rotten". On 24 March, the progress notes stated "sores re-dressed — still not looking good", and on 26 March, "getting more dependent on caregivers to feed her and hold her drinks". On 27 March, the progress notes stated "sore on left hip getting worse", and on 28 March, "called out just about every time I turned her". There is no evidence that during this period Ms C amended the care plan, called for medical advice, or sought other professional advice. There is also no evidence that Ms C ordered, or performed, any basic observations (blood pressure, pulse, temperature, respirations) or monitored Mrs A's fluid or food intake.

Ms C explained that she would have informed Mr B of the deterioration in Mrs A's condition on 27 March, as she was due days off, and that nothing was done in her absence until she called Dr F on 1 April. However, there is no evidence that Ms C informed Mr B of Mrs A's change of condition, and no documentation of any increased concern. Ms C was at

work at the rest home on 30 March, as is evidenced by her completion of Mrs A's wound-care plan on that day.

Conclusion
Mrs A required ongoing and increasing nursing care while at the rest home. The person primarily responsible for that care was Ms C. While there is evidence that Ms C provided nursing care to Mrs A, she did so at a very basic level and did not respond appropriately to Mrs A's deteriorating condition. There is no evidence that Ms C sought advice from another health professional with respect to the choice of treatment for Mrs A. Mr Neville advised that Ms C had available to her the local district nurses, the local District Health Board, and professional organisations such as the College of Nurses Aotearoa (NZ), all of whom could have provided guidance on the care of Mrs A.

I accept Mr Neville's advice that Ms C was working outside her scope of practice, but consider that her conduct overall cannot be explained or excused by this fact. Mr Neville stated that it is the "registered nurse's full responsibility to ensure that competence to practice in the area of older people's health is maintained". There is no evidence that she sought further training or recognised that she was in fact working outside her scope of practice.

In my opinion, Ms C failed to provide appropriate nursing care to Mrs A, and breached Rights 4(1) and 4(3) of the Code.

Breach — The rest home

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for employees' breaches of the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

Ms C was an employee of the rest home, and had been so for 16 years. Mr B knew that Ms C was a registered psychiatric nurse. Mr B also knew that Ms C had not been provided with formal training. She therefore could not provide the relevant guidance for staff, appropriate assessment of patients, or fulfil the job for which she was employed. It was the rest home's responsibility as an employer and as a provider of health and disability services to ensure that all staff were appropriately qualified and trained, and that adequate systems were in place to ensure staff did not breach the Code.

In my opinion, Ms C was primarily responsible for the planning and assessment of Mrs A's care. In employing Ms C, a registered psychiatric nurse, to provide general nursing advice and care, the rest home is vicariously liable for Ms C's breaches of the Code.

Opinion: No Breach — Dr D

My investigation also examined the care provided by Dr D. The information obtained during my investigation was reviewed by my in-house clinical advisor, who advised: "[Dr D] could have been more assertive and proactive on behalf of his patients but … he did provide a reasonable standard of medical care for his patients in a situation of suboptimal nursing care where management appear resistant to his intervention."

Dr D was reliant on Ms C, as the only registered nurse at the rest home, to communicate information that allowed him to choose an appropriate plan of care. Mrs A's main problems were pressure sores and pain management.

Dr D stated that on 19 March 2003 the pressure sores were not a major cause for concern; if they had been, he would have referred Mrs A to the public hospital, as he had done for "a number of other residents at the rest home who had severe pressure sores". There was no proper documentation or assessment of the extent of Mrs A's pressure sores. Her pressure sores were not formally assessed by nursing staff until 8 April 2003 at the nursing home, almost three weeks later. There is no evidence that Dr D was advised about any deterioration in Mrs A's condition before 19 March 2003, when he ceased to be responsible for her.

There is no reference in Dr D's notes to any difficulties in Mrs A's pain control. Given that Ms C stated that, in her opinion, Mrs A's calling out was not due to pain, it is perhaps unsurprising that she did not bring the matter of pain control to Dr D's attention. Mrs A's pain appeared to be at its worst when she was turned. It is unlikely that Dr D would have been present at such times to assess her pain first-hand.

Having reviewed the clinical record, I am satisfied that Dr D provided Mrs A with an acceptable standard of care. Dr D examined Mrs A when requested, amended her medications when appropriate, ordered wound swabs be taken, and gave advice on the management of her pressure sores. Accordingly, I am satisfied that he did not breach the Code.

Follow-up actions

- Ms C and the rest home will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Nursing Council of New Zealand, with a recommendation that it consider reviewing Ms C's competence. A copy of the final report will also be sent to the Licensing Office at the Ministry of Health, and the Health of Older People Portfolio Manager at the relevant District Health Board.

- A copy of this report, with details identifying the parties removed, will be sent to the College of Nurses Aotearoa (NZ) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, on completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings considered the matter and decided to issue proceedings before the Human Rights Review Tribunal against the rest home, the manager, the licensees and the nurse. Prior to the hearing of the matter all of the defendants agreed to declarations being made by consent that the nurse, the rest home, the manager and the licensees had all breached the Code.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.