Te Whatu Ora Nelson Marlborough

(formerly Nelson Marlborough District Health Board)

Springlands Senior Living Limited

(trading as Springlands Lifestyle Village)

A Report by the

Aged Care Commissioner

(Case 19HDC01145)

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Executive summary

1. This report discusses the care provided to an elderly man at Springlands Lifestyle Village (Springlands) and Wairau Hospital (Te Whatu Ora Nelson Marlborough) in 2018. It highlights the importance of providing appropriate wound care and having adequate systems and guidance in place to support staff to do so.

Findings

2. The Aged Care Commissioner found that Te Whatu Ora Nelson Marlborough breached Right 4(1) of the Code for failing to provide an appropriate standard of care in relation to wound management, and for the lack of adequate guidance in place for its staff at the time of the man's care, in particular regarding the management of pressure injuries.

3. The Aged Care Commissioner found that Springlands breached Right 4(1) of the Code for its failure to provide an appropriate standard of care for his pressure injury.

Recommendations

4. It was recommended that both Te Whatu Ora and Springlands provide the family with a written apology for their respective breaches of the Code. It was also recommended that both providers report to HDC on the effectiveness of the changes made since the man's care, and on any further improvements made.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her father, Mr A, at Springlands Lifestyle Village (Springlands) and Te Whatu Ora Nelson Marlborough.[1] The following issues were identified for investigation:

- *Whether Springlands Senior Living Limited provided Mr A with an appropriate standard of care during Month2[2] to Month4 2018 (inclusive).*
- *Whether Nelson Marlborough District Health Board provided Mr A with an appropriate standard of care during Month2 to Month4 2018 (inclusive).*

6. This report is the opinion of Aged Care Commissioner Carolyn Cooper and is made in accordance with the power delegated to her by the Commissioner.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to Nelson Marlborough District Health Board now refer to Te Whatu Ora Nelson Marlborough.

[2] Relevant dates are referred to as Months 1–4 to protect privacy.

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7. The parties directly involved in the investigation were:

Springlands	Provider
Te Whatu Ora Nelson Marlborough	Provider
Ms B	Daughter of consumer

8. Registered Nurse (RN) C is also mentioned in the report.

9. Further information was received from a hospice and the Nationwide Health and Disability Advocacy Service.

10. Independent advice was obtained from Nurse Practitioner (NP) Jenny Phillips (Appendix A).

Information gathered during investigation

Introduction

11. This report concerns the care provided to Mr A by Te Whatu Ora Nelson Marlborough and Springlands in 2018, in particular regarding Mr A's wound care and management.

12. Mr A, aged in his eighties at the time of events, had been a resident of Springlands receiving rest-home level care since 2014. Springlands provides rest-home and hospital-level care for up to 56 residents. Mr A's medical history included a cerebellar stroke, high blood pressure, paroxysmal atrial fibrillation,[3] and anaemia.[4]

Overview of care from Month2 to Month4

13. Over the period of care discussed in this report, Mr A was transferred between Wairau Hospital (Te Whatu Ora Nelson Marlborough) and Springlands three times. This is summarised below with each instance addressed separately.

14. On the morning of 25 Month2, Mr A had an unwitnessed fall at Springlands and was transported to Wairau Hospital Emergency Department (ED). Following assessment, it was confirmed that Mr A had suffered a hip fracture. He was admitted to the Inpatient Surgical Unit and underwent hip surgery later that day.

15. Mr A remained in Wairau Hospital until 13 Month3, when he was discharged back to Springlands. Three days later, on 16 Month3, Mr A was again transferred to Wairau Hospital on the instruction of his GP due to a likely antibiotic-resistant urinary tract infection (UTI). He received treatment at Wairau Hospital until 19 Month3, when he was discharged back to Springlands.

[3] An irregular, rapid heart rate that begins suddenly and usually lasts less than one week and stops on its own without treatment.

[4] Insufficient healthy red blood cells to carry adequate oxygen around the body.

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16. On 25 Month3, Mr A was transferred to Wairau Hospital once more (the third time in one month) due to a fever. He was diagnosed with sepsis[5] of unknown origin. On 3 Month4, following discussion with the family, Mr A was transferred to hospice for symptom management and palliation. However, following an improvement in his condition, on 7 Month4 he was transferred back to Springlands for hospital-level care. Mr A remained at Springlands until he passed away. My condolences to his family.

17. I wish to acknowledge that Mr A's daughter, Ms B, raised several concerns about the care her father received from 25 Month2 until 10 Month4, and HDC has endeavoured to address these concerns. However, the focus of this report is the specific areas of concern identified by HDC's independent nursing advisor, NP Jenny Phillips, in relation to wound management in Month3.[6]

Wairau Hospital — Month3

18. On 9 Month3, nursing staff at Wairau Hospital commenced wound management charts/care plans for Mr A concerning three abrasions — on his left elbow, left foot, and left calf. Each chart noted the following information: a description of the wound, the level of exudate[7] (nil to moderate), whether the wound was odorous (nil for each), a description of the surrounding skin (normal, swollen, bruised), dressing plans, and how often the dressing should be changed (every three days). The charts contain a section for recording the dimensions of the wounds in centimetres, but this was left blank for all three wounds. Neither the wound charts nor the nursing notes state how long the wounds had been present.

19. On 12 Month3, nursing staff commenced a fourth wound management chart for a pressure injury on Mr A's left heel. Information regarding the pressure injury was documented in the same manner as the above wound charts. The pressure injury was described as 'Black areas, intact blister', with a recommendation to review the dressing in '3–5 days'. This was the sole entry made on this chart. Again, the dimensions of the pressure injury were not recorded, nor how long it had been present. There was also an absence of documented staging of the pressure injury.[8] (The accepted international grading system for pressure injuries includes four main stages (1 to 4) that describe localised injury to the skin and/or underlying tissue in order to plan for effective treatment.[9])

20. At the time of Mr A's care, Te Whatu Ora Nelson Marlborough did not have its own comprehensive pressure injury policy in place to provide guidance to its staff around identification, assessment and management of pressure injuries. Te Whatu Ora told HDC that it relied on the following guidance for management of pressure injuries: the New

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[5] A life-threatening medical emergency resulting from an infection.

[6] The relevant parts of NP Phillips' advice are included in the opinion sections of this report.

[7] Fluid exuding from the wound.

[8] Pressure and treatment of pressure ulcers: Quick reference guide, 2014: https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf.

[9] 'Unstageable' (depth unknown) and 'suspected deep tissue injury' (depth unknown) are two additional classifications under this system where it is not possible to classify under stages 1–4.

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Zealand Wound Care Society (NZWCS) advisory guideline for pressure injuries, and the one-page Nelson Marlborough DHB 'Heel and Sacral Pressure Injury Prevention Guideline', which provided guidance on the application of 'Mepilex' dressing for pressure injuries in the heel and sacrum areas. The latter guideline states that for stage 1–4 pressure injuries, care should be recorded on the 'Wound Care Assessment Form' (wound management chart).

21. A pressure injury on Mr A's left heel was documented several times in the nursing notes in the weeks prior to the completion of the pressure injury wound management chart on 12 Month3. In particular:

- On 31 Month2, Mr A underwent a pressure injury risk assessment that noted the presence of a pressure area on his left heel, and he received a Waterlow score of 14. (The Waterlow score is an assessment that determines an individual's risk of developing a pressure injury. A score of 10+ is 'at risk'; 15+ is 'high risk'; 20+ is 'very high risk'.)
- On 2 Month3, notes state: '[P]ressure area noted on [left] heel? Depth unknown. Dark purple area noted. Mepilex heel applied.'
- On 6 Month3, notes state: '[Patient] heel noted pressure point blackened small,' and '[H]eel mepilex replaced on [left] heel … small blackened area above [left] heel.'
- On 10 Month3, notes state: '[Pressure area left] heel — skin not broken, looks like a blister.'

22. On 12 Month3, the nursing notes state: '[P]ressure area [left] heel has formed blister but still intact', and that a dressing was applied. As noted above, on this day a wound management chart was completed for the pressure injury on Mr A's left heel.

23. On 13 Month3, Mr A was discharged back to Springlands, as he was considered to have recovered sufficiently after his surgery. Information provided to Springlands by Wairau Hospital included a 'Patient Transfer Information' form, a discharge summary, and a copy of the wound management charts. The transfer form noted that Mr A's pressure risk was 'high', that the need for a pressure-relieving mattress was also high, and that he had an existing pressure area. The discharge form noted that Mr A had a left heel 'skin tear' and the plan for Springlands nurses to continue wound cares and monitor for infection. Te Whatu Ora stated that its clinical nurse co-ordinator also provided a verbal handover to Springlands regarding the ongoing care of Mr A's pressure injury and wounds.

Discharge to Springlands

24. Mr A was transferred back to Springlands in the early afternoon of 13 Month3.

25. Springlands' 'Pressure (related Deep Tissue) Injury Prevention Policy' at the time stated:

> 'The Registered Nurse will assess all Residents during the admission assessment process, to identify risk factors associated with the possible formation of pressure injuries. Any existing breaks in the Resident's skins will be noted and a plan developed to promote their healing.

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The Registered Nurse is responsible for developing, and reviewing all wound care interventions. … All referrals will be noted in the Resident's care plan evaluation, progress notes and on the Pressure Injury Risk Assessment Tool.'

26. On admission back to Springlands, no wound care plan was completed. Springlands acknowledges that this was an oversight. There was also no staging completed for the pressure injury. Springlands told HDC that at the time of care, the Clinical Nurse Manager was responsible for day-to-day clinical care, and the nurse who covered rest-home level care residents was RN C. Springlands said that both staff were spoken to following receipt of an initial complaint from Ms B in Month4, and both acknowledged the error in not completing the required documentation of a wound assessment care plan. However, Springlands also told HDC that nevertheless, it considers that the appropriate care was provided to Mr A regarding his pressure injury.

27. Progress notes at 9.50am on 13 Month3 record that Mr A told a healthcare assistant that he had sore heels. However, no assessment of his heels was undertaken at this time. Other than the administration of pain-relief medication, the clinical records do not make any mention of care regarding Mr A's wounds until 1pm on 15 Month3, when a healthcare assistant documented: 'Assisted [Mr A] to shower … dressings removed RN to re-dress.' However, the nursing note at 4.15pm that day does not record any wound assessment or care undertaken. Despite Wairau Hospital's transfer note stating that the need for a pressure-relieving mattress was high because of the existing pressure area, there is no record that this was considered or implemented by Springlands staff.

Second admission to Wairau Hospital

28. On 16 Month3, following a review by his GP, Mr A was readmitted to Wairau Hospital due to concerns that he had an antibiotic-resistant UTI. His GP also noted a history of confusion, and on the previous day Springlands staff had informed Ms B that Mr A was 'having confusions … [and] short term memory loss'. It was noted on admission to Wairau Hospital that Mr A reported a decrease in mobility and that he was having ongoing pain in his left heel and calf. Ms B told HDC that when a nurse removed the dressings from Mr A's pressure injury, the nurse commented that it was 'smelly'.

29. A pressure risk assessment was completed, which gave Mr A a Waterlow score of 22, placing him in the very high risk category for developing pressure injuries. The guidelines in the assessment form for those at very high risk recommended that a gel or air/pressure mattress be put in place. However, there is no evidence that a pressure mattress was put in place until 29 Month3.

30. Nursing notes on 19 Month3 state that Mr A's heels were elevated on a pillow, and noted the following wound cares: 'Dressings removed, wounds cleaned and redressed — 2x skin tears [left forearm, 1x [pressure area left] heel (deflated blister) — all clean, surrounding skin ok.'

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31. No wound management charts were completed for Mr A's pressure injury or any other wounds during this admission to Wairau Hospital, nor were any additional entries made on the existing charts during this admission. There was no staging of the pressure injury, or details about its size or for how long it had been present.

32. In the early afternoon of 19 Month3, Mr A was discharged from Wairau Hospital and transferred back to Springlands. A patient transfer information form was provided to Springlands, which stated, 'Skin/wound care — as before', with a comment: '2x skin tears [left] elbow, [pressure area left] heel, [left] calf skin tear. Please monitor. … All wounds redressed 19 [Month3].' A verbal handover was also given to Springlands regarding Mr A's pressure injury and wound care.

Discharge to Springlands

33. On 20 Month3, RN C carried out a comprehensive assessment of Mr A's pressure injury and recorded the assessment on Springlands' Wound Assessment, Treatment and Evaluation Plan. RN C described the wound as: 'Stage [2] pressure ulcer (blister bursted). Location: [left] heel. Size: 2.5x2cm.' RN C documented the wound dressing objective as being to 'promote healing [and] prevent infection'. The dressing was changed and the form recorded that the next dressing should be done in one week's time on 27 Month3.

34. On this date, an Adverse Events report was lodged in relation to the pressure injury.[10] The report documented the size of the pressure injury and noted that it was '[h]ospital acquired'. Instructions within the report were to encourage Mr A to reposition every two hours, to 'check daily pressure points to ensure no new pressure injury', and to ensure that the left heel had a heel protector on at all times. Nursing notes document that a pillow was replaced under Mr A's heels.

35. Mr A's wound care is not mentioned further in the clinical notes during this period of care at Springlands and prior to Mr A's next hospital admission. On 25 Month3, the clinical notes state that Mr A was unwell with a fever and a reduced level of consciousness, and he was transported back to Wairau Hospital.

Third admission to Wairau Hospital

36. On assessment at Wairau Hospital on 25 Month3, the clinical records note: 'Heel pressure sore — dressing removed and assesse[d], foul smelling, wet wound, necrotic tissue surrounding.' A pressure injury risk assessment was completed on this day, with a Waterlow score of 18. Nursing records also note the need for a pressure mattress for Mr A's left heel, and that the pressure injury was redressed.

[10] Springlands' Pressure Injury policy at the time stated: 'Pressure injuries are generally considered to be a treatment related injury and must be recorded on an adverse event form.'

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37. On this admission, Mr A was diagnosed with 'sepsis ?source — most likely chest or urinary', and treated with intravenous (IV) flucloxacillin (an antibiotic). The notes document the left heel pressure sore and an impression of chronic hyponatraemia.[11]

38. On 29 Month3, it was noted that Mr A had been placed 'on [a] pressure relieving mattress'. On 30 Month3, a doctor noted that following a meeting with the family, it was agreed that if Mr A deteriorated then care would be withdrawn and palliative care initiated.

39. On 3 Month4, the clinical records note: 'Confused today. Informed family that [antibiotics] are not beating the infection. Son suggested hospice.' The discharge summary states:

> '[A]fter thorough discussions with patient's family, it was agreed to withdraw antibiotics and stop all unnecessary medications and aim for symptomatic management. Family meeting with hospice team, agreed to [discharge] patient to hospice for palliation, family declined sending patient back to rest home for palliation.'

40. Mr A was admitted to hospice care on 3 Month4.

End-of-life care

41. The Nationwide Health and Disability Advocacy Service's referral letter to HDC states that Ms B was informed by a doctor that Mr A would remain at the hospice for the remainder of his life. A letter from hospice nursing staff to Mr A's GP on 7 Month4 advised that the hospice admission was for 'symptom control'. A further letter on the same day from hospice medical staff to Mr A's GP stated that Mr A was admitted to the hospice for 'terminal care'. The letter also noted the possibility that the source of the sepsis was the pressure injury on Mr A's heel.

42. A note by hospice medical staff on 3 Month4 states: 'If [Mr A] plateaus or stabilizes he would be happy to return to [Springlands] (hospital level care). It was also recorded on 4 Month4 that Mr A 'was happy with care at Springlands and if continues stable would like to transfer back'.

43. A letter to Mr A's GP on 7 Month4 states that Mr A had recovered from his infection enough to be discharged to hospital-level care at Springlands.

44. Ms B told HDC:

> 'At the meeting at Wairau Hospital on 3 [Month4], with a hospital Doctor, Hospice representative, and my brothers and I, we agreed to Dad stopping the IV antibiotics if he wasn't responding but that he be admitted to [hospice] for palliative care rather than [Springlands] hospital wing. … At no stage was it discussed at the meeting, that my father was being sent to [hospice] "for symptom stabilisation prior to longer-term

[11] Below normal levels of sodium in the blood.

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placement depending on progress". To our knowledge he was being sent for palliative care.'

45. On 7 Month4, Mr A was readmitted to Springlands for hospital-level care. The following day it was recorded that Mr A was deteriorating clinically, and, after speaking to his family, comfort cares for symptom management commenced. Mr A died on 10 Month4.

Further information

Ms B

46. Ms B is concerned that the sepsis may have been caused by an infection at the site of the pressure injury, which had been noted as 'foul smelling' by Wairau Hospital staff on 25 Month3.

47. In relation to the transfer back to Springlands from the hospice on 7 Month4, Ms B told HDC: 'Dad thought he would go back to his old room, and instead went into the Hospital room. He was very confused, didn't even know he was in Springlands.'

Te Whatu Ora Nelson Marlborough

48. Te Whatu Ora extended its condolences to Mr A's family. It acknowledged that assessment of Mr A's level of risk for pressure area injury was 'not regularly considered', and the family's concerns regarding Mr A's care prior to his death. Te Whatu Ora said that it 'sincerely apologises' to the family for the grief caused by Mr A's death, and further stated:

> '[Mr A] and his whānau/family trusted [Te Whatu Ora Nelson Marlborough] to ensure he received safe and appropriate care in our hospital and we did not honour their whakapono/faith in us. We are very sorry they did not get to spend more time together as a family and for the distress they have suffered.'

49. Te Whatu Ora Nelson Marlborough told HDC that at the time of events it did not have in place its own comprehensive pressure injury policy to provide appropriate guidance to its staff around identification, assessment and management of pressure injuries. It acknowledged that this was a departure from the accepted standard of care.

Springlands

50. Springlands told HDC that it believes it provided Mr A with an appropriate standard of care during Month2 to Month4. In particular, Springlands submitted the following:

- The clinical records reflect that Mr A experienced an ongoing deterioration in his health from 4 Month1 onwards;
- The ongoing decline in health and admissions in and out of hospital made it difficult to provide an appropriate level of care;
- There were 'interventions and assessments completed by Springlands nursing staff in relation to his changing health condition and care needs'; and
- It had in place sufficient policies and procedures, which were reviewed on a regular basis.

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51. At the time of events, Springlands had a three-year certification from the Ministry of Health. The certification audit, conducted in November 2016, noted partial attainment in the area of wound care. Specifically, it noted that some pressure injuries had not been reported as an incident, and that not all wound-care documentation had been completed fully or updated. A surveillance[12] audit conducted on 10 April 2018 noted that assessments and wound management plans were in place but were not always reviewed according to timeframes. The audit also noted that where wound documentation had been completed fully, 'a new shortfall around timely wound evaluations and care plan interventions had been identified'. Springlands has since implemented changes in wound management, as outlined in the 'Changes made' section below.

Responses to provisional opinion

52. Te Whatu Ora and Springlands were given the opportunity to respond to the provisional report, and both accepted the findings.

53. Ms B was given the opportunity to respond to the 'Information gathered during investigation' section of the provisional report. Ms B reiterated her concerns about the care her father received, which she believes was not appropriate.

Opinion: Te Whatu Ora Nelson Marlborough — breach

54. Independent advice was obtained from NP Jenny Phillips to assist my assessment of the care provided to Mr A at Wairau Hospital. NP Phillips identified areas of concern in Mr A's care from about 9 Month3 onwards, and my opinion has focused on these key areas.

Wound care

Pressure injury policy

55. In relation to Mr A's wounds and wound care, NP Phillips advised that 'pressure injuries are a serious and at times life threatening injury'. She considers that not having a comprehensive pressure injury policy in place at Wairau Hospital in 2018 was a serious departure from accepted standards of care. Te Whatu Ora accepted that this was a departure from the accepted standard of care and said that the lack of a comprehensive policy meant that there was 'an absence of overarching guidance to support and inform development and delivery of the care plans'.

56. While there was some instruction for staff in patient care plans/wound charts about how to deliver care for pressure areas, I am critical that there was no comprehensive pressure injury policy in place at Te Whatu Ora to adequately support its staff in providing an appropriate standard of care to Mr A for his pressure injury.

[12] A surveillance audit is a periodic audit — a 'snapshot in time' — to ensure that an organisation is meeting the standard requirements or, in the case of a partial attainment finding, that this has been rectified.

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Omissions in care and assessment

57. In relation to the severity of Mr A's pressure wound, NP Phillips noted that his Waterlow score of 22 (on 16 Month3) placed him in the 'very high risk' category and indicated that his health was compromised. NP Phillips advised that while a recommendation in the hospital form was for Mr A to have a gel or alternating air mattress put in place, 'there was no mention of a pressure mattress being used until [9am] on the 29th [Month3], very near the end of care'. She said that the delay in implementing this action was too long from when Mr A was first recorded to require it.

58. The reason for the delay in supplying a pressure mattress for Mr A at Wairau Hospital during his admissions of 16–19 Month3 and from 25 Month3 is uncertain. It is unclear whether no mattress was available on site, or whether the systems in place were inadequate to ensure that a mattress was provided promptly when needed. Te Whatu Ora told HDC that in 2018 there was a lack of detailed record around the provision of pressure mattresses to patients, and it was unable to provide any clarity around the reason for the delay. In any event, and notwithstanding that Mr A was at Springlands from 19–25 Month3, I am critical of the delay in providing a pressure mattress at Wairau Hospital, particularly in light of the recommendation being made by its own staff, and I am concerned that no acceptable reason for the delay can be identified.

59. NP Phillips identified further omissions in relation to evidence of appropriate management of Mr A's wounds at Wairau Hospital, including documentation in the wound management charts. On 9 Month3, a wound chart was commenced for three separate abrasions on Mr A's left side, and the wound chart for his left heel pressure injury was commenced on 12 Month3. NP Phillips advised:

> 'For all wounds accepted practice is to complete a full assessment (commonly using the TIME[13] pneumonic — see appendix 1) and also noting where the wound is, the size and how long it has been present. The site of the pressure injury and abrasions was the only aspect recorded. … For pressure injuries there should also be a classification using (in 2018) the 2014 international pressure injury classification.[14] … Throughout the nursing notes and the [wound charts] the wounds were usually mentioned by site and then it was stated that they were redressed. Occasionally the product was mentioned but there was no clear plan identifying what nurses were hoping to achieve and what the actual state of the wounds were.'

60. NP Phillips further stated: 'There is a fault with the care plan in that it states dressing plan, but not the aim of wound care such as "deslough wound in 2 weeks".' NP Phillips also

[13] Tissue (non-viable); Infection (and/or inflammation); Moisture (imbalance); Edge (of wound non-advancing).

[14] The international classification system includes four categories/stages of pressure ulcers (I to IV) that describe and classify localised injury to the skin and/or underlying tissue, as well as two additional categories (unstageable and suspected deep tissue injury) that describe pressure injury for which the full extent of damage to the tissue and skin remains unknown. (Pressure and treatment of pressure ulcers: Quick reference guide, 2014: https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf.)

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commented: 'In general wards there was sporadic recording of wounds including the left heel, but specifically that it was a pressure injury was often not mentioned.'

61. NP Phillips advised that there was no evidence of wound charts being initiated or completed for the second hospital admission on 16 Month3, when Ms B said she was told that the wound was 'smelly'. In relation to the wound assessment undertaken at Wairau Hospital on 19 Month3, NP Phillips noted that again there was no staging of the pressure injury on the left heel, as well as no size provided. NP Phillips noted that the international staging system for pressure injuries is used to assist everyone with 'talking the same language and providing effective treatment according to the stage of the pressure injury'.

62. NP Phillips' advice is that there was a failure to adhere to section 4 of the Nursing Council Code of Conduct (2012)[15] to provide safe and competent care by delivering care based on the best available evidence and practice and maintaining clear and accurate records; and competency 2.2 of the Nursing Council's Competencies for Registered Nurses (2016)[16] to undertake comprehensive and accurate nursing assessments based on suitable tools and methods.

63. Overall, NP Phillips advised that there was a moderate departure from accepted practice in Te Whatu Ora Nelson Marlborough's care of Mr A's wounds, although she considered that it would be only a low level of departure for the individual nursing staff involved due to the lack of comprehensive guidance from Te Whatu Ora at the time. I agree.

Conclusion

64. In light of NP Phillips' advice, which I accept, I am critical that at the time of Mr A's care, Te Whatu Ora did not have in place sufficient policies and procedures to support its staff adequately with regard to the identification, assessment and management of pressure injuries. The absence of such guidance may have contributed to the departures from accepted practice in the management of Mr A's wounds. The clinical records lack important information about Mr A's wounds and their management, and his pressure injury was not staged adequately as per the standard international guidelines. In addition, although wound management charts were completed towards the end of Mr A's first admission at Wairau Hospital, there is a concerning absence of such wound chart entries for his admissions of 16 and 25 Month3 when the pressure injury was still present, and when a pressure injury was recognised by staff several times prior to the commencement of the pressure injury wound chart on 12 Month3.

65. In light of the above, I find that Te Whatu Ora breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[17] for failing to provide Mr A with an

[15] The Code of Conduct can be viewed in full at: https://online.flippingbook.com/view/359830702/2/.

[16] The Competencies can be viewed in full at: file:///H:/Downloads/NCNZ006-Competencies-Registered-Nurses-15-08-2022v0.1pdf%20(1).pdf.

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

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appropriate standard of care, and for the lack of adequate guidance in place for its staff regarding the management of pressure injuries.

Opinion: Springlands Senior Living Limited — breach

66. This opinion discusses the care provided to Mr A at Springlands from 13–16 Month3 and 19–25 Month3. Springlands completed wound-care plan documentation for only the second of these periods. Ms B said that on her father's admission to Wairau Hospital on 16 Month3, a nurse told her that Mr A's pressure injury was 'smelly', and it was documented on Mr A's admission to hospital on 25 Month3 that the pressure injury was 'foul smelling'.

13–16 Month3

67. My independent advisor, NP Phillips, considers that it was a medium departure from accepted practice that Springlands did not complete a thorough assessment of Mr A's wounds on 13 Month3 following his transfer from Wairau Hospital. She advised that accepted practice would have been for Springlands staff to have inspected Mr A's heels when he complained that they were sore on 13 Month3, but there is no record that this occurred. NP Phillips said that the failure to complete a thorough assessment did not comply with section 2.2 of the Nursing Council's Competencies for Registered Nurses regarding the requirement to undertake comprehensive and accurate nursing assessments based on suitable tools and methods.

68. NP Phillips advised that Te Whatu Ora provided Springlands with adequate transfer information to enable appropriate follow-up of Mr A's pressure injury and wound care. NP Phillips also raised concerns that there was no mention of any dressings to the heel until 15 Month3, when 'it simply said dressings removed'.

69. I accept the above advice and am critical that Springlands did not manage or care for Mr A's pressure injury appropriately in the period 13–16 Month3. Wairau Hospital had provided Springlands with all the necessary information, including wound charts, upon Mr A's transfer back to Springlands, but there is no evidence that Springlands completed the appropriate care plan or cares for the pressure injury during that period. I am particularly critical that even when a healthcare assistant recorded on 13 Month3 that Mr A had complained of sore heels, it appears that no appropriate care was given to that concern.

70. Springlands said that the nursing staff responsible for Mr A's care during this period acknowledged the error in not completing the required documentation, but submitted that nevertheless the appropriate care was provided to Mr A in relation to his pressure injury.

71. I disagree. Given the failures identified above, there appears to be little basis for the assertion that the care of the pressure injury at this time was appropriate, and I accept NP Phillips' advice that the omissions discussed above amount to a departure from accepted standards of care.

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19 Month3

72. Regarding the further care at Springlands from 19 Month3, NP Phillips advised that the wound-care plan and assessment completed on 20 Month3 was comprehensive — including the size and staging of the pressure injury — and was to the expected standard. However, she stated: 'My only criticism would be that on the 20th they said to redress the wound on the 27th, which is probably too long, and the wound should have been checked probably 3 days later.'

73. NP Phillips also advised that when Mr A's pressure injury was described as being 'smelly' when he was re-admitted to Wairau Hospital, it 'seems surprising that Springlands had not noticed this' prior to his hospital transfer.

74. I accept NP Phillips' advice that the wound-care plan on 20 Month3 was appropriate, but I am concerned that Mr A's pressure injury was allowed to become 'foul smelling', as documented on his admission to Wairau Hospital on 25 Month3. This indicates that the pressure injury was not re-evaluated when required after the initial assessment, and I note NP Phillips' advice that the pressure injury should have been re-dressed on 23 Month3, which would have enabled such a re-evaluation. I am critical that this did not occur. In addition, given that at that time Mr A was at very high risk of developing pressure injuries and required a pressure mattress (given the most recent Waterlow assessment score of 22 on 16 Month3), I am very concerned that there is no evidence of whether Springlands considered the need for a pressure mattress.

Discussion

75. Springlands contends that at times it was difficult to provide Mr A with an appropriate level of care 'due to his ongoing decline in health and admissions in and out of hospital,' and believes it managed his change in level of care 'as best it could'. Springlands submitted that overall Mr A was provided with an appropriate standard of care. However, as discussed above, I consider that the omissions in the care provided, taken together, amount to a significant departure from the accepted standard, as follows:

- Between 13 and 16 Month3, the care provided for Mr A's pressure injury was inadequate, despite Springlands having been provided with adequate transfer information by Wairau Hospital to enable appropriate follow-up of the injury, and despite Mr A complaining of left heel pain.
- On 20 Month3, when Mr A's most recent Waterlow assessment was in the 'very high risk' category for pressure injury, the decision was made to re-dress the pressure injury in another seven days, rather than in three days. In addition, there is no evidence that the need for a pressure mattress was considered at this time.
- It is concerning that on re-admission to Wairau Hospital on 16 and 25 Month3 Mr A's pressure injury was noted to be smelly. This had not been noted by Springlands staff prior to his admission, and I find it likely that the aforementioned omissions in care at Springlands contributed to the poor state of Mr A's pressure injury at those times.

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Conclusion

76. In light of the issues identified above, I find that between 13 and 25 Month3 Springlands failed to provide Mr A with an appropriate standard of care for his pressure injury, and breached Right 4(1) of the Code.

Springlands — other comment

77. I note that Ministry of Health audits carried out at Springlands in 2016 and 2018 identified some concerns in the area of wound care. The 2016 audit noted that not all wound-care documentation had been completed fully or updated. The 2018 audit noted that where wound management plans were in place, these were not always reviewed when required, and that a 'shortfall around timely wound evaluations and care plan interventions had been identified'. While I acknowledge that Springlands has since made changes in the area of wound management, what the above demonstrates is that the omissions identified in Mr A's case were not isolated incidents, and the failure to remedy those matters sooner may have contributed to the omissions that occurred during Mr A's care.

End-of-life care — other comment

78. I note Ms B's concern about the end-of-life care for her father, in particular regarding his transfer back to Springlands following his admission to the hospice in Month4. It is clear that Mr A's family understood from their discussions with Wairau Hospital and hospice staff that Mr A was going to the hospice for palliative care, and that he would remain there until his death. It was also documented in hospital notes that the family specifically declined sending Mr A to Springlands for end-of-life cares. However, Mr A was transferred back to Springlands from the hospice after only a few days because it was thought that he had recovered from his infection sufficiently. Ms B said that during these final days, her father 'didn't even know he was in Springlands'.

79. The documentation regarding the end-of-life care plan refers variously to 'palliation', 'symptomatic management', 'symptom control', and 'terminal care'. Ms B stated: '[A]t no stage was it discussed … that my father was being sent to [hospice care] for symptom stabilisation prior to longer term placement depending on progress.'

80. This issue highlights the importance of clear communication with patients and their families concerning care plans, particularly when a patient is nearing the end of life, when a dignified and informed care journey is all the more important. It is clear from the clinical records throughout the period of care discussed that Mr A often experienced confusion, and this may have been exacerbated by the frequency with which he was transferred to different facilities in his final days and weeks. Prior to the decision to admit Mr A to hospice care, it would have been critical for Mr A and his family to have understood that if his condition improved sufficiently at the hospice, there was a possibility that he could be transferred back to Springlands. If the family had understood this, it may have affected their decision

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on where they wished for Mr A to be transferred following his discharge from Wairau Hospital on 3 Month4.

81. I take this opportunity to remind all healthcare providers that it is essential to ensure that consumers and their families are fully informed about the care being recommended or undertaken, in particular around the management of end-of-life care, so that they experience the necessary dignity in care and can make informed choices about that care.

Changes made

Te Whatu Ora Nelson Marlborough

82. Te Whatu Ora told HDC that in 2020 it joined an ACC initiative for Prevention and Management of Pressure Injuries, the aim of which is to reduce the incidence and severity of pressure injuries. Te Whatu Ora said that currently it is progressing a project plan to achieve this goal, which includes having two project managers based at Nelson and Wairau Hospitals, who provide leadership, mentoring and support to clinical teams around pressure injury prevention and management. Te Whatu Ora said that improvements achieved by the project to date include:

- The implementation of a Te Whatu Ora Nelson Marlborough Pressure Injury Prevention and Management Policy and Procedure in June 2020. (NP Phillips advised that this is 'an excellent, evidence-based document'.)
- Quicker access to a wider range of pressure-relief mattresses with reduced time delay between request and delivery.
- Introduction of Pressure Care Champions into its model of nursing care 'so early intervention by nurses directly delivering care can be enacted'.

83. Since 2018, the education opportunities for Te Whatu Ora Nelson Marlborough nursing staff to develop their practice in preventing pressure injuries and wound care has increased significantly, with courses including a Wound Study Day, and E-Learning courses for Wound Care and Pressure Injury Prevention attended by over 70 staff each year since 2019.

84. Since 2019, Te Whatu Ora has been implementing the Deteriorating Patient Programme to support early recognition and escalation of patients who are becoming more unwell. Te Whatu Ora told HDC that by mid-2021, 279 staff had completed its Deteriorating Patient training, which it confirmed had delivered significant improvements in patient care.

85. Te Whatu Ora said that since the events of this complaint, it has been progressively implementing a new electronic observations system (Patientrack) across its hospitals, which allows patient vital signs and other clinical data to be recorded at the bedside using a handheld device. Te Whatu Ora said that following admission, all patients have a suite of risk assessments completed in the admission form within Patientrack, which includes a

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number of mandatory questions for the initial assessment of pressure injury risk. Based on a patient's Waterlow score, Patientrack then identifies an appropriate 'Bundle of Care for Pressure Injury Prevention' to be put in place, and schedules regular reassessments of the patient's Waterlow score as required.

Springlands

86. Springlands told HDC that in 2019/2020, it moved to electronic care planning via Healthcare Compliance Solutions Limited (HCSL). It said that HCSL provides a more effective way of gathering information that can be collated and referred to in one place. Springlands advised that HCSL alerts staff to when information is missing, and 'in some cases does not allow movement through certain pages until all fields are complete'. Springlands said that the new HCSL system will prevent any omission to complete a wound care plan from occurring again.

Recommendations

87. I recommend that Te Whatu Ora provide a written apology to Mr A's family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B and her family.

88. I recommend that within two months of the date of this report, Te Whatu Ora report to HDC on the effectiveness of the above changes made since these events, and whether any further improvements have been identified or implemented since those changes.

89. In the provisional report it was recommended that Springlands provide a written apology for its breach of the Code identified in the report. In its response to the provisional report, Springlands provided the written apology to HDC, and this has been forwarded to Ms B.

90. I recommend that within two months of the date of this report, Springlands report to HDC on the effectiveness of its new HCSL system in the prevention of omissions in care, including wound care planning, and any other improvements made to its services.

Follow-up actions

91. A copy of this report with details identifying the parties removed, except the advisor on this case, Te Whatu Ora Nelson Marlborough, Wairau Hospital and Springlands Senior Living Limited (trading as Springlands Lifestyle Village), will be sent to HealthCERT (Ministry of Health) and Te Tāhū Hauora|Health Quality and Safety Commission and placed on the HDC website, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from NP Jenny Phillips:

'**Response to HDC complaint.**

Wairau Hospital (Nelson Marlborough DHB)

The management of [Mr A's] pressure injury and abrasions during his admission to Wairau Hospital.

For all wounds accepted practice is to complete a full assessment (commonly using the TIME pneumonic — see appendix 1) and also noting where the wound is, the size and how long it has been present. The site of the pressure injury and abrasions was the only aspect recorded. The assessment and regular re-assessments form the basis of the care plan with any subsequent changes. An example of this can be seen in the Springlands wound documentation.

For pressure injuries there should also be a classification using (in 2018) the 2014 international pressure injury classification[1]. This guideline was updated in 2019. This guideline should form the basis of any policy within the DHB as they are an international document.

Throughout the nursing notes and in the generic wound care plan section the wounds were usually mentioned by site and then it was stated that they were redressed. Occasionally the product was mentioned but there was no clear care plan identifying what nurses were hoping to achieve and what the actual state of the wounds were. There was one exception to this when the wound on the left calf was described as sloughy with high exudate. On the 16th [Month3] when he was re-admitted, the pressure injury was described as smelly.

There were frequent mentions of keeping [Mr A's] heels off the bed by use of pillows which is a recommendation for heel sores[1] and he did receive sporadic assessment with the Waterlow score, although when his score went 22 — very high risk, a recommendation in the hospital form was for gel or alternating pressure mattress to be used. There was no mention of a pressure mattress being used until 21.00 hours on the 29th [Month3], very near the end of care.

Breaches in this section fall under section 4 of the Nursing Council Code of Conduct to provide safe and comprehensive care by delivering care based on the best available evidence and practice and maintaining clear and accurate records. Also Competency 2.2 of the Registered nurse competencies to undertake comprehensive and accurate nursing assessments based on suitable tools and methods.

Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings. Indicator: Undertakes assessment in an organised and systematic way. Indicator: Uses suitable assessment tools and methods

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to assist the collection of data. Indicator: Applies relevant research to underpin nursing assessment.

I consider this a medium level departure from care, however, if the hospital does not provide the policies, guidelines and charts (such as a wound chart) for nurses to work to this does make their job difficult.

Following further documentation and review this is [downgraded] to a low level departure from care. See below.

Wairau did have a wound chart. There was an initial assessment of his wounds on this, including his heel pressure injury, although this was still not graded. There is a fault with the care plan in that it states dressing plan, but not the aim of wound care such as "deslough wound in 2 weeks". Wound care charts should be filled in at each dressing — if there is no change this can be a tick with the date to indicate a dressing change, but if the treatment changes then the assessment needs to be redone to reflect why. The pressure injury was first recorded on the 12th [Month3] and the patient was then transferred on the 13th. I have not seen any wound charts for the second admission to Wairau, but there were mentions in the nursing notes that the wound was smelly. The instructions on the wound chart do not state to fill in at each dressing change, so given the lack of guidelines or policies for nurses, this can be downgraded to a low level departure from care.

The decision to discharge [Mr A] from Wairau Hospital on 13 [Month3] and 19 [Month3].

13th [Month3]. There were several meetings around this and he was discharged from A & R to the Rest Home. On the 13th the physio recorded that [Mr A] was independently walking for short periods with a walking frame and that he required minimal assist with 1 person from sitting to lying. The nursing notes for the 11th–13th [Month3] record [Mr A] as afebrile, in good spirits and mobilising to and from the day room independently with a walking frame and requiring help just to lift his left leg back into bed. Based on this there is no apparent reason why he should not have been discharged back to the Rest Home. He was re-admitted on the 16th but this was because of an antibiotic resistant urinary tract infection — he had not responded to the antibiotic prescribed on discharge, and there was no way this could have been foreseen on the 13th.

19th [Month3]. [Mr A] had been confused, especially at night, however he was mobilising for short distances on his frame and required 1 person to assist with ADL and assistance to lift his legs onto the bed. He was afebrile and the possibility of a DVT had been excluded. His daughter was concerned about ongoing physiotherapy, but the nursing staff explained that he would continue to receive this under ACC. There would seem to be no medical reason for him to stay in hospital and discharge to the Rest Home was a reasonable decision.

There is no apparent departure from standards of care or accepted practice.

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The patient transfer information provided to Springlands Lifestyle Village on 13 [Month3] and 19 [Month3]

13th [Month3] — I could find no specific transfer form for this discharge as there was for the 19th [Month3]; again, there was mention of wounds present but no specific care plan. The transfer forms were completed but had not been submitted with the first set of documents, and there was also a verbal handover.

19th [Month3] — minimal information, wounds listed and although stated a pressure ulcer on left heel, was not staged. Wounds redressed on the 19th before discharge, but no information on what dressings were being used, transfer record simply stated to monitor wounds. There was slightly more detail on the wound on the calf which was inflamed, but still nothing related to how it was being dressed.

His risk of falls was noted as high on the standard transfer form, but none of the strategies in use to prevent falls were ticked as a guide for Springlands.

[Addendum:] There is no departure from standards of care in these instances as adequate information was passed to the Rest Home as shown in the additional documents provided by Nelson and Marlborough.

The assessment undertaken by staff for [Mr A's] wound on 19 [Month3]

The notes recorded that there was a pressure injury on the left heel which was a "deflated blister all clean" — again no staging of the pressure injury, no size provided and verbal advice was given to monitor wounds.

Low departure from standard of care as they did not have policies and information on staging pressure injuries provided by the DHB, but they could have recorded measurements.

Any other matter you consider warrant comment.

I have seen no evidence of a policy (pressure injury or wound) which should lay out preventative and treatment measures. The pressure injury was not staged but was recorded on "the ACC form" when the patient was in AT & R, which would be to claim with ACC as a Treatment injury. In the general wards there was sporadic recording of wounds including the left heel, but specifically that it was a pressure injury was often not mentioned. The medical notes did not even recognise that the heel wound was a pressure injury on the 16th they recorded a *"flap wound on the left heel (? ulcer)".* The international grading system for pressure injuries is to assist everyone with talking the same language and providing effective treatment according to the stage of the pressure injury. I would recommend that Wairau Hospital instigate a comprehensive pressure injury policy which all staff are aware of.

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If there is no comprehensive pressure injury policy this would be a serious departure from accepted standards of care from the provider, not for individual nurses as pressure injuries are a serious and at times life threatening injury.

April 2022 review — further review following additional documents provided:

The hospital is to be commended on the comprehensive and evidence-based education programmes and related policies which have now been introduced and the inclusion of education around pressure injuries to patients and their family/whānau. Their appointment of Pressure injury champions and planning for the 2022 pressure injury week show a real commitment to moving everything forward in a positive way. The only area which seems to require more work — as demonstrated by their graph on Pressure injury by stage — is the fact that a large number of patients are still not having pressure injuries graded, and this universal language really does assist with understanding the extent of the injury. Their new documentation along with regular audits should provide a much clearer picture and pathway to follow should there be any issues raised in the future.

In terms of the original report, the term "PAC given" or equivalent can be ambivalent as these need to be specific to each patient. For example, this patient had his legs elevated on pillows to protect his heels from pressure and this was mentioned, but what other PAC were specific for him were not outlined. If there is an individual care plan for PAC clearly written, then the phrase PAC given can be written in the notes.

Given the time since the complaint, it is not surprising that the nurses cannot remember specifics of this case. Typically nurses such as in statement 15 assume they have completed certain care and documentation — unfortunately there is the old adage "if you don't write it down it never happened". Statement 16 states the necessary paper work was sent to the Rest Home but does not define what that is.

Individual culpability: In terms of individual culpability, given that the Hospital did not have up to date policies it would not be reasonable to apportion blame to any one individual. The management of Wairau concede the lack of clear direction in terms of comprehensive policies and procedures in paragraph f in their recent letter.

<u>**Springlands Lifestyle Village**</u>

Wound care provided to [Mr A] following his transfer from Wairau Hospital on 13th [Month3] and 19th [Month3].

13th [Month3] — The transfer note from the hospital included the type of dressing in use and indicate that [Mr A] had had inadine and Mepilex foam applied to his left heel before leaving hospital, and he had also had a Waterlow risk assessment score completed. Springlands did not complete a wound assessment form on this discharge and although a [healthcare assistant] reported that he had sore heels on the 13th, there was no mention of any dressings to the heel until the 15th when it simply said dressings removed. There is no record that his heels were inspected when he complained they

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were sore, and this would be accepted standard of practice. The DHB noted on re-admission on the 16th that the wound was smelly, and it seems surprising that Springlands had not noticed this.

Waterlow score: There is a wealth of information on the Waterlow risk assessment score to be found in print and on line. Waterlow assesses different aspects of patients which include: build, weight for height; visual assessment of the skin (which would include any breaks); sex/age; continence; mobility; appetite and special risk factors which include tissue malnutrition, neurological deficits, major surgery, trauma and medication. Each category has a score and patients scoring over 20 are deemed at very high risk of developing pressure sores, or indeed often already have them. A delay from the [16th] of [Month3] when [Mr A] scored 22 on the Waterlow score and the 29th when he was first recorded to have a pressure mattress installed is too long a time to implement cares indicated. A high Waterlow score indicates that [Mr A] was compromised — the score sheet would show which areas were the most serious, but apart from relieving the pressure his overall condition would be seriously impacting tissue viability. Correct use of the Waterlow score is that each area where a high score is recorded is addressed where possible, e.g. if nutrition or continence are highlighted are there ways of managing/improving these, whereas some medical issues might not be manageable. A pressure relieving mattress is used to try to reduce pressure injuries occurring or worsening on patients who have been identified as at high risk. Springlands have the Waterlow score actions in their policies — over 18 score:

VERY HIGH RISK (18 or above)

ALL OF THE ABOVE

+

Use alternating pressure-reduction mattress IF Resident has hard-to-control pain;

OR

Severe pain exacerbated by turning

OR ADDITIONAL RISK FACTORS eg. Palliative care needs

*alternating pressure-reduction mattresses do not substitute for turning schedules — in other words still need to reposition the patient and keep heels free of pressure

OTHER GENERAL CARE ISSUES

NO massage of bony prominences;

NO Donut/Ring type devices;

Maintain good hydration;

NO vigorous drying of skin.

Frequent skin checks.

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Ensure pressure mattress pressure is maintained at appropriate pressure for weight of resident. Check should be recorded each shift in progress notes or on care chart.

Skin Assessment: Each time the resident is repositioned

[Month3] 19th — As the patient had had his wounds redressed before discharge, the wounds were redressed and assessed by Springlands on the 20th [Month3]. There is a comprehensive assessment and care plan provided in the Springlands notes which also includes the size and staging of the pressure injury, which was recorded as a Stage II pressure injury measuring 2.5x2.5. My only criticism of their care plan would be that it does not provide a section for what the treatment objectives are, however, they clearly state the dressing to be used and how often to provide treatment.

There were 2 very different levels of care provided here. There was no breach on the discharge on the 19th [Month3] with the most comprehensive documentation of his wounds and the pressure injury throughout his whole episode of care across the various settings.

On the 13th there was a breach under 2.2 of the Nursing council competencies around lack of assessment. He should have had a thorough assessment, and particularly as he was complaining that his heels were sore. This would be a medium level departure of care, and they have the policies in place so that this should have occurred.

Documentation of wound assessment undertaken by nursing staff at Springlands Lifestyle Village.

Springlands have the type of wound assessment and care plan document that I would expect to see in any facility and which was lacking in the Wairau Hospital notes. There is an initial assessment and then a tick chart for ongoing assessment. They also staged the pressure injury, the first time this had been done. The care plan — dressings to use — are documented and the nurse can then write that care is provided as per the care plan. My only criticism would be that on the 20th they said to redress the wound on the 27th, which is probably too long, and the wound should have been checked probably 3 days later. None of this documentation was used on the discharge on the 13th.

On the 13th the staff failed to meet competency 2.2 from the Nursing Council but on the 19th there were no breaches of this competency.

Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings. Indicator: Undertakes assessment in an organised and systematic way. Indicator: Uses suitable assessment tools and methods to assist the collection of data. Indicator: Applies relevant research to underpin.

The adequacy of Springlands Lifestyle Village's Wound and Skin Care Management policy.

Springlands has an extremely comprehensive wound and skin care management policy with references provided. They also referenced the ACC document (Appendix 2) which

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every health provider was meant to be using following its launch in 2017 and which is endorsed by ACC, Health Safety and Quality Commission and the Ministry of Health. It had not at this time been rolled out to Wairau. Included in this is also the SSKIN bundle (see below) which Springlands have in their policy. **S**urface; **S**kin inspection; **K**eep moving; **I**ncontinence; **N**utrition.

The standard of care is to provide the best evidence-based care possible and Springlands policies are based on well referenced up to date international and national guidelines and recommendations. They also meet the ACC principles and particularly around 5 — care planning and implementation using evidence based bundles of care — this includes the SSKIN bundle.

Any other matters you consider warrant comment

There are no further comments.

April 2022 review and conclusion following provision of further documentation

No change in review. Springlands admit in the new documentation that the wound assessment on the 13th [Month3] was not done, otherwise the supplied documents support my previous conclusion that they are working with comprehensive evidence-based policies and documents, which I also note have been updated and renewed in 2020.

Hospice

The appropriateness of discharging [Mr A] to Springlands Lifestyle Village for palliative care.

The hospice discharged [Mr A] following consultation with him and his family and admit that it was unfortunate that he had a rapid deterioration following discharge, which was not anticipated. The family were informed of the criteria for using the minimal hospice beds and that there was a CNS available in the community and telephone access 24 hours a day with hospice staff. Springlands is a provider able to provide generalist palliative care. The CNS was called to the rest home on the 8th [Month4] and visited as required after that to advise and assist staff and [Mr A].

The hospice met the following 2 standards of care from the Standards for Palliative care (2019). These have been updated since the episode of care, but the basic principles remain the same.

Paerewa 2: Te whakarite mahere manaaki tāngata/Standard 2: Developing the care plan

The team works in partnership with the person, their family, whānau and carers, to communicate, plan, set goals and make informed decisions about their care plan.

Paerewa 5: Te whakawhitinga o ngā ratonga/Standard 5: Transitions within and between services

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Palliative care is accessible to all people who need it and it is integrated and coordinated across the person's experience to ensure seamless transition within and between services.

Any other matters you consider warrant comment

No other matters.

Peer review for all questions. I consider that any of my peers would be of the same opinion having read all the notes and referred to all the available evidence, guidelines and current accepted practice.

References:

1. European pressure ulcer advisory panel, National pressure ulcer advisory panel, pan pacific pressure injury alliance. Prevention and treatment of pressure ulcers: Quick reference guide (2014)
2. Nursing Council Code of Conduct 2012. Nursing Council of New Zealand
3. Competencies for Registered Nurses 2007. Nursing Council of New Zealand

Jenny Phillips
Nurse Practitioner

16 November 2020.

Additional review comments:

Falls prevention: [Mr A] fell on 25 [Month2] at Springlands. Springlands have a comprehensive falls prevention policy which includes a screening tool. It is not clear whether this was completed for [Mr A] as I could not find one in the notes and the couple of days before the fall the notes simply state that he was doing independent cares which suggests he was mobilising without any need for assistance. The policy states that individual plans are needed for at risk clients, but presumably at this time he did not fall into this category. I note that his health was reported to be declining from [Month1] onwards, and it is possible that this increased his risk of falls, which could have been reflected in a re-assessment if one was done. When he was discharged from Wairau on 25th [Month3], there is a good example from the physiotherapist who covered all the mobility needs and aids that [Mr A] required at that time.

Wairau had a very comprehensive policy and falls assessment which was used for each admission. A physiotherapist was involved in his risk assessments and in fact on 25th [Month2] judged him not fit for transfer to Springlands as he still required 2 people to assist him. There is a good example from the physiotherapist who covered all the mobility needs and aids that [Mr A] required at that time when he was discharged on [Month3] 25th, he had been back to Springlands between these times.

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Pressure relieving mattresses: Availability of these depends on arrangements organisations have for them, broadly speaking there are 3 common ones: Purchasing 2–3 for use at any time. Renting a small number on a permanent basis OR arranging that they can be provided on rental within 24 hours of request. Trying to sort rental and supply with a company on a need basis — which can result in supply delays, however, other strategies such as 30 degree tilt and turning can be used in the meantime.

Further review completed May 2023.

Jenny Phillips'

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