G J & J M Bellaney Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01024)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by G J & J M Bellaney Limited over a period of two months in 2017. A number of oversights in the man's care relating to the communication of falls and pressure injuries, and the management and documentation of his pressure injuries, resulted in the pressure injuries not being well managed and his family not being kept informed.

2. This report highlights the importance of providers communicating effectively with one another and with the consumer's family, and of ensuring that clinical assessments and care plans are comprehensive and actioned, and that documentation is completed to a good standard to support care and decision-making, including on the transfer of care to another provider.

Findings

3. The Deputy Commissioner found G J & J M Bellaney Limited in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that G J & J M Bellaney Limited (a) did not communicate information about the man's falls and pressure injuries adequately; (b) did not manage his pressure injuries adequately; and (c) recorded limited documentation and did not provide written handover on the man's transfer to another provider.

4. The Deputy Commissioner made adverse comment about the Clinical Nurse Manager. The Deputy Commissioner was critical that the Clinical Nurse Manager did not provide sufficient overall review of the man's care, particularly in the last few days of his stay.

Recommendations

5. The Deputy Commissioner recommended that G J & J M Bellaney Limited (a) provide a formal written apology to the family; (b) consider gaining access to a more specialised level of nursing; (c) clarify guidelines and agreed protocol for accessing specialist advice; (d) schedule regular and ongoing education sessions on specified topics; (e) use an anonymised version of this report as a case study; and (f) provide HDC with an update on the effectiveness of the changes made following these events, and the results of audits in relation to the changes.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by G J & J M Bellaney Limited to her father, Mr B. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mr B (dec) by G J & J M Bellaney Limited in Month4 and Month5 2017.*

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

8. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's daughter
G J & J M Bellaney Limited	Provider
RN C	Provider/Clinical Nurse Manager

Also mentioned in this report:

Ms D	Mr B's daughter
Dr E	General practitioner
RN F	Registered nurse
Medical centre	

9. Further information was received from:

Registered Nurses (Facility 2)	
Facility 2	Provider
District health board	
HealthCERT	

10. Independent clinical advice was obtained from Registered Nurse (RN) Julia Russell and is included as **Appendix A.**

Information gathered during investigation

Introduction

Mr B

11. Mr B, aged in his eighties at the time of events, had a history of dementia, type II diabetes, coronary heart disease, and hyponatraemia.[1] He had been a resident at the rest home since 2015 and required dementia-level care. Mr B's daughter, Ms D, held an enduring power of attorney for personal care and welfare and property for Mr B.

12. By Month4, Mr B's physical and cognitive abilities were deteriorating. He was presenting with fluctuating eating patterns, mobility issues, reduced ability to understand conversations, and an increasing need for full assistance with daily living activities such as washing, dressing, and toileting. In Month4 and Month5, Mr B had two falls and developed pressure injuries, in particular an unstageable[2] pressure injury on his left heel. On 27 Month5, Mr B was transferred to another facility (Facility 2) for hospital-level care. The

[1] Low sodium concentration in the blood.
[2] Full thickness tissue loss in which the base of the ulcer is covered by slough or eschar.

pressure injuries were notified to the district health board (DHB) and HealthCERT[3] after he was transferred from the rest home.

Rest home

13. At the start of 2017, the rest home provided dementia-level care for up to 38 residents. During the year, the facility was reviewed for service readiness to provide hospital-level (geriatric and medical) and rest-home level care, and this was approved on 20 Month4. The rest home is owned and operated by G J & J M Bellaney Limited and is contracted by the DHB to provide rest-home level and hospital-level care to consumers.

14. At the time of these events, the Clinical Nurse Manager and Business Facility Manager were responsible for the daily operation of the rest home.

Clinical Nurse Manager

15. RN C was employed by the rest home as the Clinical Nurse Manager (CNM) in 2012. She was responsible for the management of the rest-home and hospital-level care.

16. RN C's job description sets out the expectations of the CNM position. Under the heading "About the rest home", the function of the CNM is stated as:

> "[T]o ensure that all residents' health requirements are maintained. The CNM is expected to at all times have an overall review of all residents' wellbeing and to give guidance and assistance, as necessary, to other staff on how to ensure residents' wellbeing."

17. Under the heading "Clinical Management", it is stated:

> "The CNM is to oversee all aspects of clinical management in the rest home [and] [e]nsure that the care provided by other members' of [the rest home's] nursing and care giving staff are of a high standard and in keeping with current best practice."

18. Under the heading "Communication", it is stated:

> "Each resident's family/whanau and POA are to be communicated with by the CNM in the event of any significant changes to a resident's status e.g.: deterioration in behavio[u]r or health. They must also be involved in any significant changes around a residents care e.g.: the need for transfer within the facility or externally."

Deteriorating health in Month4 and Month5

19. During Month4 and Month5, Mr B was seen by Dr E of the medical centre. On 6 Month4, Dr E reviewed a keratotic growth at the base of Mr B's right index finger and a fungal-infected fingernail. A removal of the lesion was planned, and terbinafine was prescribed for the fungal infection. At Mr B's routine monthly review on 16 Month4, the planned

[3] HealthCERT within the Ministry of Health is responsible for ensuring that hospitals, rest homes, residential disability care facilities, and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.

surgery was noted and Dr E recorded: "[N]o current problems." On 20 Month4, Dr E performed minor surgery on Mr B's hand. The incision healed well.

20. On 6 Month5, Ms D telephoned the medical centre to express concern that the terbinafine could be correlated with Mr B's deteriorating health, and to request that the prescription be stopped to see if his health improved. Dr E contacted the rest home for further information. RN C emailed Dr E, explaining:

> "[Since [Mr B] commenced terbinafine on 6 Month4,] he has been bothered by gastro-intestinal symptoms up to and including vomiting on one occasion. He appears pale and tired. His appetite, always poor is almost non-existent at present. Obs[ervations] are within normal limits."

21. On 7 Month5, Dr E faxed instructions to the rest home: "Agree — STOP Terbinafine."

22. On 10 Month5 at 2.30pm, RN C reviewed Mr B and changed his dietary profile. She checked his sore toes and a rash on his back, arms, and stomach, and advised the healthcare assistant to apply urea cream.[4]

23. On 11 Month5 at 6.45am, Mr B's rash was itchy, and the healthcare assistant reported this to the registered nurse, who examined Mr B and took observations. The itching reduced after a shower and application of urea cream. At 1.15pm, RN C examined Mr B and took observations. She noted that the rash was similar to a rash Mr B had had on admission, which was of unknown cause but had resolved with treatment, and recommended the use of a cradle at night for the pressure areas.

24. On 12 Month5, RN C emailed Dr E for advice, stating:

> "[Mr B's] frailty continues and is getting worse over time. Discontinuing terbinafine has had no appreciable effect on his presentation."

25. RN C listed Mr B's problems, including his conversation being more muddled, regularly needing assistance from two people to complete ADLs,[5] eating less, unintentional weight loss, being tired and weak, deterioration in his walking and toileting, and the development of a rash on his back.

26. On 14 Month5, it is recorded in the progress notes that the rash had "settled well" following treatment with urea cream over the preceding days.

27. On 18 Month5, Ms D telephoned RN C regarding a GP consultation for Mr B. RN C recorded in the the Family/Whānau/Resident representative Contact sheet (the family contact sheet): "I explained that [Dr E] [was] away and due to the complexity of [Mr B's] health care it [would be] better to wait for his return. [Ms D] agreed to this." RN C arranged a meeting with Ms D for 21 Month5 to discuss Mr B's assessment and the process from there.

[4] Applied to the skin to treat dryness and itching.
[5] Activities of daily living.

28. On 18 Month5, RN C commenced an interRAI reassessment[6] for Mr B, which was completed on 20 Month5. This was a "significant change in status assessment", and the results indicated that Mr B needed to be assessed for a higher level of care. A needs assessment and service co-ordination organisation (NASC) was requested to assess Mr B for a change in level of care.

29. On 21 Month5, the progress notes record that RN C "sat with [Ms D] and took her through assessment comments". RN C informed Ms D that Mr B had been referred for a reassessment of his level of care, and that if he needed hospital-level care he would be transferred to one of the beds in the hospital wing, and the family could then decide whether they wanted alternative accommodation for him. The note records: "[Ms D] is happy with this plan."

30. Dr E returned from leave on 24 Month5, and at 9.13am RN C emailed Dr E stating: "Further to the previous email on 12th Month5, [Mr B's] condition continues to deteriorate, despite no longer being on antifungal medication." RN C noted that the rash had disappeared, that Mr B was still alert when awake over the weekend, and that he was no longer able to stand, and morning staff had used the hoist to transfer him. She also conveyed the family's concern and comments that previously when Mr B had had hyponatraemia, the family had observed a similar presentation.

31. In the email, RN C requested that Dr E visit that day, and stated that she had referred Mr B to the NASC for reassessment to hospital-level care. She noted that she would follow up with the practice nurse regarding the last blood test for electrolytes.

32. Dr E reviewed Mr B on 25 Month5 and ordered blood tests and a urine specimen. The consultation summary was faxed to the rest home at 2.01pm and the family notified. Dr E wrote: "Over the last few months [Mr B] has gradually been getting more disinterested/dependent and less mobile." Dr E's notes indicated that Mr B required a wheelchair, needed to be fed and transferred, had had fine twitching at times over the last week, had a reduced level of consciousness, reduced weight, and poor eye contact, but was in no apparent pain or distress and looked well otherwise.

33. Dr E's plan of care was to add calcium and TSH[7] to the blood tests ordered, obtain a urine sample if possible, and to prescribe a course of antibiotics (for a possible UTI) to start after a week if there was no improvement. The blood tests were normal. Dr E recorded that he was "not convinced the terbinafine caused this current malaise/illness".

34. On 26 Month5, Mr B was assessed by the NASC as needing hospital-level care.[8] The progress notes record that the family were informed of this, and they requested that Mr B be transferred to Facility 2 the following morning (27 Month5).

[6] A long-term care facility assessment.
[7] A thyroid stimulating hormone (TSH) test is done to check thyroid function.
[8] The highest level of care given to residents in a care home, including end-of-life care or palliative care and respite care.

Falls

Fall — 24 Month4

35. On 24 Month4 at 4.30pm, Mr B had an unwitnessed fall in the dining room courtyard at the rest home. The adverse event incident form records that the incident was reported to the senior healthcare assistant and that Mr B had a small skin tear on his right elbow. The progress notes record that the tear was dressed.

36. The incident was not reported to the registered nurse on site in the hospital/rest-home wing, or to RN C as the CNM. RN C told HDC that this was in line with the Falls Prevention Programme,[9] as "The Instructions in the Event of a Fall" section of the policy states that the registered nurse is to be notified if there is a problem with weight bearing. However, the adverse event incident form records: "Action taken at the time of incident was appropriate except not reported to RN. This has been discussed with staff involved."

37. On 28 Month4 at 9.00am, RN C reviewed the incident form, assessed Mr B, and recorded that he had a small healing skin tear on his right elbow. She told HDC that after the assessment, "there were no issues to pursue with his health status".

38. On 29 Month4, lines of communication were discussed at the team meeting regarding the reporting of incidents to the registered nurse. At 12.05pm, the family contact sheet records that RN C telephoned Mr B's daughter, Ms D, and informed her of the fall on 24 Month4. The record states that Ms D "had not been notified of this previously". Under the heading "Communication", the Falls Prevention Programme at the rest home states that "[r]esidents family (Next-of-kin/EPOA) must be notified of all resident falls". No timeframe is given.

Fall — 20 Month5

39. On 20 Month5 at 6.00pm, Mr B had an unwitnessed fall in the TV lounge at the rest home. The adverse event incident form records that the incident was reported to RN F by a healthcare assistant at 6.30pm, in accordance with the falls policy. The form recorded: "[I]t appears [Mr B] leaned over his wheelchair and it tipped sideways causing [Mr B] to fall out."

40. The progress notes state that Mr B was given paracetamol for pain relief, and that neurological observations were maintained as per RN F's instructions. At 7.30pm, the notes record: "[P]upil reaction equal, responds well — able to recall his name and date of birth." At 8.30pm, 9.30pm, and 10.30pm Mr B's pupil reaction was recorded as equal, and it was noted that he was responding well. The next entry in the progress notes at 7.00am on 21 Month5 states that Mr B "slept well, no concerns".

41. The family contact sheet shows that RN C contacted Ms D on 21, 24, and 25 Month5, but there is no mention of having informed the family of Mr B's fall on 20 Month5. RN C reviewed the adverse event incident form on 4 Month6. The form records: "CNM not notified of this incident so was unable to f/u[10] in a timely manner." The Falls Prevention

[9] Issued 20 Month5.
[10] Follow-up.

Programme at the rest home states that "[r]esidents family (Next-of-kin/EPOA) must be notified of all resident falls". RN C acknowledged that "there was a gap in communication with the family".

Pressure injury management

Short term care plan (STCP) 29 Month1

42. On 29 Month1, a short term care plan (STCP) was put in place by RN F for a "pressure area 4 x 3cm on R[ight] heel, 1 x 1cm on L[eft] heel". RN F recorded the following three interventions: (a) keeping the feet on a soft pillow during the day when seated; (b) trialling soft protective boots in bed; and (c) daily review and then a progress review on 3 Month2. On 2 Month2, the family contact sheet shows that Ms D was informed about Mr B's pressure area.

43. On 1 Month3, RN C added a fourth intervention — having a pillow at the end of the bed to keep the weight of the bed clothes off Mr B's feet. Progress was evaluated and recorded on 30 and 31 Month1, and on 2, 5, and 8 Month2. The pressure injuries were managed, and by 2 Month2 the left heel area had healed, and by 8 Month2 the right heel area had reduced in size from 4 x 3cm to 2 x 3cm. RN C stated that this showed that the rest home had previously managed and healed a pressure sore on Mr B's left heel.

44. On 25 Month4, a healthcare assistant recorded in the progress notes that Mr B's "L[eft] foot [was] very swollen". On 27 Month4, RN C recorded in the notes that she had checked Mr B's ankles, and that the left ankle was more swollen than his right ankle up to his mid-calf. The plan was to review him the next day.

45. At 4.00pm on 28 Month4, RN C assessed Mr B after reviewing the incident form from his fall on 24 Month4. She recorded that she found no issues to pursue regarding his health. On 29 Month4, RN C telephoned Ms D regarding Mr B's fall on 24 Month4, and recorded on the family contact sheet that they "talked about [Mr B's] continuing fragility".

46. There is no further mention of Mr B's left foot or ankle being swollen, and the next mention of sore areas on his feet is on 10 Month5, when a healthcare assistant recorded in the progress notes at 1.50pm: "2 small sore red areas on both big toes. Reported to CNM [RN C]." At 2.30pm, RN C reviewed Mr B's toes and a rash he had developed, and also reviewed his dietary profile. The healthcare worker recorded at 10.30pm that a "cradle [was] placed in [Mr B's] bed to help with his sore toes".

47. On 11 Month5 at 1.15pm, RN C examined Mr B and noted: "[Mr B] has an area on the top of each big toe that looks like a pressure injury." She recorded: "[P]lease make sure socks are loose on toes, has soft shoes on & uses bed cradle at night." On 12 Month5, RN C emailed Dr E to report Mr B's general decline. Dr E was on leave. On 15 Month5, it is recorded in the progress notes: "[Mr B] appears to be well, good mobility when using the walker."

48. On 17 Month5, it is recorded: "[Mr B] required 2 x HCA this duty is very frail." A healthcare assistant recorded: "[Mr B has] a weeping pressure area on left heel, dressing applied, also ankle bone area looking red."

49. At 5.30am on 18 Month5, it is recorded: "[P]illow put under calves of legs to keep heels elevated. Rolled towel and put between legs to stop pressure rubbing." At 9.20pm, the progress notes record that a pillow was used to elevate Mr B's heels to keep pressure off them.

STCP 19 Month5

50. On 19 Month5, RN F put in place an STCP for a "pressure area on L[eft] heel … to heal, and avoid undue pressure at heels", with objectives to heal the wound and for Mr B to be pain free. The interventions included asking Mr B each shift whether he required pain relief, and "dressing change daily to assess progress". No information regarding staging of the injury was recorded, no photographs of the wound were taken, and no guidance on pressure-relieving measures was provided. RN F recorded in the progress notes that the "dressing [was] changed @ L[eft] heel", that Mr B had taken little food, that he was responsive but tired, and that he was "[unable to] weight bear, 2 person assist".

51. At 1.45pm on 20 Month5, the progress notes record: "[Mr B] had L[eft] leg resting up against the bed foot frame causing small dent in lower L[eft leg." This was reported to the registered nurse. At 6.20pm, the dressing on the left heel was changed.

52. The progress notes on 21 Month5 record at 1.45pm that Mr B was not weight bearing. At 3.00pm, the left heel dressing was changed by a nurse. At 9.30pm, the notes record: "[Mr B is] able to weight [bear] but has no sense of balance."

53. On 22 Month5, the left heel dressing was changed at 1.15pm by a nurse. Mr B was described as "sleepy at times, eating moderately. Hands appeared shaky sometimes." At 11.00am on 23 Month5, the left heel dressing was changed by a nurse who recorded in the STCP that the skin around the wound was pink and "pain was evident". The progress notes state: "[G]ranulating[11] at centre. Check daily, change if soiled, otherwise change 2/7[12]." Mr B was not weight bearing at all and was very shaky.

54. On 23 Month5, the pressure injury had reduced in size from 2cm x 3cm on 19 Month5 to 2cm x 2cm. Measurements of the pressure injury were taken and the dressing changed daily up to and including 23 Month5. The dressing was to be changed every second day from 23 Month5. There were no more entries on the STCP after 23 Month5.

55. Dr E returned from leave on 24 Month5, and RN C sent an email requesting that he "please come and visit [Mr B] today". The email followed on from RN C's request for advice from Dr E on 12 Month5. At 4.00pm, the medical centre rang RN C and confirmed that Dr E would visit Mr B the next day. Ms D was informed of the visit.

[11] Forming multiple small prominences in the wound as part of the healing process.
[12] Every second day.

STCP 25 Month5

56. Dr E assessed Mr B on 25 Month5. RN C recorded in the progress notes that Mr B's family were notified of the contents of the GP report. There is no mention of Mr B's pressure injuries in the GP report, and no indication that these were brought to Dr E's attention.

57. RN C put in place a further STCP for Mr B on 25 Month5, as Mr B was "developing [a] pressure injury on [his] sacrum — reddened areas with abrasion — hips red. Toes on both feet showing signs of pressure." The plan specified pressure-relieving methods to be taken, including when in bed being "tilted from side to side every 2 hours using pillow", use of a bed cradle, use of "slippery sam" when transferring in bed, and during the day use of a pressure-relieving cushion and soft-toed shoes. There was no information regarding staging of the injury, and no photographs were taken.

58. At 8.15pm on 25 Month5, the healthcare assistant recorded that Mr B was "settled into bed with music going". There is no mention of using the pressure-relieving methods outlined in the STCP.

59. The subsequent entry is at 5.30am on 26 Month5, which reads: "[Mr B] asleep on all checks." At 2.30pm, a healthcare assistant recorded in the notes: "[S]mall skin breaks on both cheeks of sacrum and small red area on R[ight] hip." At 7.30pm, a healthcare assistant recorded that Mr B was "positioned on side with pillow between legs as redness on inner knee area. He[e]l oozing as well. Rail insert in bed to keep blankets up."

60. The next entry in the progress notes is at 6.35am on 27 Month5, which states: "[Mr B] asleep on all checks." It is recorded in the notes that Mr B had "pressure sores on R[ight] hip & 2 skin breaks on both cheeks of sacrum". There is no record of the STCP of 25 Month5 being implemented by staff. On 27 Month5, RN C entered the following on the evaluation section of the STCP: "[C]ondition of toes has improved. R[ight] hip deteriorating. Sacrum breaking down." At 11.30am, Mr B was transferred to Facility 2 for hospital-level care.

61. RN C acknowledges that the documentation by the healthcare assistants at this time was limited. She told HDC: "[W]e cannot be certain that this last STCP was completely followed." There is no record of the rest home staff accessing external health professionals for advice, as per the rest home's Pressure (related Deep Tissue) Injury Prevention Policy, or of Mr B's family being informed about the state of his pressure injuries.

Transfer to Facility 2

62. At 11.30am on 27 Month5, Mr B was transferred to Facility 2 for hospital-level care at the request of his family. The rest home did not provide a written referral at the time of discharge. In the progress notes, RN C recorded that she "spoke with [a nurse] and gave handover", and the progress notes at Facility 2 state: "No medications or paperwork sent over."

63. RN C stated in her Month6 review:

> "The time between [Mr B] being assessed as needing hospital level care, his family being informed and his discharge was barely 24 hours. This short length of time put pressure on the discharge process."

64. RN C told HDC that the written information on the interRAI and MediMap[13] records were transferred to Facility 2 on Mr B's discharge. The interRAI reassessment was completed on 20 Month5, and stated: "[Mr B has] a stage one pressure injury on his left heel. STCP is in place." The interRAI reassessment was undertaken before the STCP was initiated on 25 Month5, and on 26 Month5 Mr B was assessed as requiring a change in the level of care. The interRAI reassessment does not capture the further deterioration, especially over the 24 hours prior to Mr B's transfer.

65. On 27 Month5, care staff at Facility 2 informed the registered nurse of Mr B's pressure injuries. The injuries were reviewed, and the left and right heel pressure injuries were measured, photographed, and dressed. On 28 Month5, the Facility Manager and CNM at Facility 2 reviewed Mr B's pressure injuries and, owing to the extent of the left heel pressure injury, completed a section 31 notification.[14] Mr B's family was also made aware of the extent of his pressure injuries.

66. On 31 Month5, the Manager at Facility 2 contacted RN C at the rest home to inform her of concerns regarding the state of Mr B's pressure injuries.

67. On 4 Month6, Dr E completed ACC forms for pressure injuries to Mr B's left and right heel and sacrum, at the request of Facility 2. The injury claim was accepted by ACC, and HealthCERT[15] was notified.

68. Mr B's health continued to deteriorate, and he died.

Further information

DHB investigation

69. On 21 Month6, the DHB investigated the lapses in documentation of Mr B's pressure injuries. The following recommendations were made regarding the rest home:

- Review and update, if required, pre-discharge nursing assessment documentation and pre-discharge documentation processes.
- Develop processes to ensure that pressure-relieving mattresses and other resources are available when needed.
- Ensure that the Facility Manager undertakes an interRAI update that includes coding, significance of outcome scores, and consistency with coding and notes.

[13] A system for medicines management.
[14] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about certain incidents, including a health and safety risk to residents.
[15] HealthCERT within the Ministry of Health is responsible for ensuring that hospitals, rest homes, residential disability care facilities, and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.

- Staff to receive training on communication processes, particularly handover, and discharge documentation.

Rest home

70. RN C acknowledged that "there was a gap in communication with the family", and added that this was not usual practice on their part, but rather a situation of "dropping the ball". She stated:

> "The situation involving [Mr B] does not reflect a chronic inability to look after him, but relates to the care received by [Mr B], and deficits in that care in the last 24 hours of his stay at [the rest home]."

In-house review of pressure injury prevention

71. RN C conducted a review of pressure injury prevention for Mr B, dated 13 Month6. She found that Mr B's pressure injury risk had not been formally assessed since 20 Month1, and the pressure injury risk assessment was last done via interRAI on 20 Month5. The written descriptions did not match the codes selected in the interRAI assessment.

72. On 26 Month5, the day before discharge, the pressure areas were checked by a healthcare assistant. It was noted that the condition of the toes had improved, but both the hip and sacrum had deteriorated. No mention was made of Mr B's left heel.

73. Although the progress notes at 7.30pm on 26 Month5 mention that Mr B's heel was oozing, there was no note of this on the handover sheet to alert the registered nurse to this. On the day of Mr B's transfer, the wounds were not dressed prior to his discharge.

74. RN C reviewed the progress notes and found that there was no indication that Mr B had been moved from his position in bed for approximately 13 hours, from about 7pm on 26 Month5 until 8am on 27 Month5. RN C stated:

> "In his frail condition, this amount of time in one position would be enough to ensure swift deterioration of his pressure injuries."

Actions taken — the rest home

75. As a result of RN C's review of the pressure injury prevention for Mr B, the following actions were taken:

- RN C discussed with RN F the need to write in STCPs all aspects of care for a pressure injury, including pressure prevention measures as well as the wound management.
- Care staff were debriefed, reminded of the importance of following care plans, and informed that if care plan directions are not followed, this will be followed up with disciplinary action.
- Registered nurses were given extra tuition on the need to repeat all assessments when a resident's condition is changing. A compulsory fortnightly, minuted meeting now occurs where all wounds, STCPs, and resident assessments are discussed.

- Photographs of all wounds, including weekly update photographs, are now taken.
- Since January 2018, incidents, STCPs, and wound treatment plans are available electronically for the CNM to access and review. RN C said that this has improved the recording and updating of records, and the care provided to residents.
- Staff training on pressure injury care and prevention was provided.
- All discharged residents are provided with a full written handover, as well as a verbal handover to the receiving facility. Discharges are now planned with a time-frame that is comfortable for the family and gives the rest home time to ensure that it can follow the Discharge/Transfer Policy for Residents.

76. In response to the recommendations from the DHB's investigation, the following corrective actions were taken by the rest home:

- The Discharge/Transfer Policy for Residents regarding pre-discharge nursing assessment documentation and process was reviewed and updated.
- Processes were developed to ensure that pressure-relieving mattresses and other resources are available when needed. More pressure-relieving equipment has been purchased, and more equipment can be sourced in a timely manner if required.
- On 20 Month7, the CNM undertook additional training on interRAI, which included coding, the significance of outcome scores, and consistency with coding and notes.
- On 26 Month7 and 26 April 2018, staff received in-service education on communication processes, particularly on handover and discharge documentation.

77. On 21 February 2018, HealthCERT received notification from ACC of a serious event involving a pressure area. HealthCERT requested that the rest home complete a Notification of Harm Report Provider Feedback Form, which was completed by RN C on 15 March 2018.

Policy

78. The rest home's policy on falls, The Falls Prevention Programme, includes:

> <u>After a fall</u>
> "Monitor for weight bearing, if has problem in weight bearing — inform RN (On Call) … Neuro-obs performed and documented in cases where head has been hit (or may have been hit)."
>
> <u>Communication</u>
> "Residents family (Next-of-kin/EPOA) must be notified of all resident falls."

79. The rest home's Discharge/Transfer Policy for Residents states:

> <u>Co-ordination</u>
> "[The rest home] ensures the transfer/discharge [of] all residents be conducted in a co-ordinated manner with the recipient care provider …"

> Documentation
> "All relevant information regarding the cares, current medication and known desires and abilities of the resident will be detailed in the transfer documentation.
>
> …
>
> The transfer document will accompany the resident on discharge from this facility and will be completed by the Registered Nurse …"

80. The rest home's Pressure (related Deep Tissue) Injury Prevention Policy states:

> "The Registered Nurse is responsible for developing, and reviewing all wound care interventions.
>
> …
>
> When pressure injuries do occur we will access external health professionals for advice, to maximise interventions designed to restore and maintain skin integrity."

81. The rest home's Wound and Skin Care Management Policy states:

> "To ensure resident's physical healing is optimal through monitoring and regular review of skin integrity and wound status.
>
> …
>
> Skin integrity checks must occur on admission and each 6 monthly InterR[AI] reassessment to identify changes.
>
> …
>
> It is advisable to take photographs of the wound, ensuring to record the exact measurements and date of photograph.
>
> …
>
> If healing is prolonged or signs of infection are present, the resident's medical practitioner must be consulted to review the wound and advise on further treatment."

Responses to provisional opinion

82. G J & J M Bellaney Limited was given an opportunity to respond to the provisional opinion, and advised that it accepts the findings and recommendations. The Director stated:

> "[A] number of changes have been made in our processes since this event and we are confident this has been fully addressed and measures put in place to avoid this happening again."

83. RN C was given an opportunity to respond to the relevant parts of the provisional opinion, and advised that she accepts the findings and recommendations. She commented that the provisional opinion was "fair and balanced".

84. Mrs A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, Mrs A's comments have been incorporated into the report above.

85. In addition, Mrs A told HDC: "[Dr E] had no idea of the falls or the shocking state of dad's pressure injuries at the time of his consultation to be able do a **thorough** and **correct** diagnosis." She stated: "[W]e never had a chance to be able to get our father the critical care he badly needed."

86. Mrs A further commented:

> "Dad's health requirements were far from maintained, his care was **sub-optimal** as well as the communication between staff and management, also withholding of information to our family."

87. Mrs A believes that failures at the rest home caused her father's "Health and Wellbeing to plummet dramatically over this period of time and cause his unnecessary demise".

Opinion: G J & J M Bellaney Limited — breach

Introduction

88. G J & J M Bellaney Limited had a duty to provide services to Mr B with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate reasonable care. G J & J M Bellaney Limited also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

> "**Service Management Standard 2.2**: The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

89. Mr B had been a resident at the rest home since 2015, but in the months of Month4 and Month5 his health began to deteriorate. I have a number of concerns about the care provided to Mr B in Month4 and Month5, relating to the communication of two falls to Mr B's family, the management of Mr B's pressure injuries, the communication of pressure injuries to Mr B's family, and the transfer of care to Facility 2.

90. There were deficiencies in the care provided to Mr B by multiple staff, which, in my view, were systemic issues for which G J & J M Bellaney Limited bears responsibility. These are outlined below.

Falls

91. On 24 Month4, Mr B had an unwitnessed fall, which was not reported to the registered nurse or Clinical Nurse Manager. The Clinical Nurse Manager, RN C, told HDC that this was in line with the Falls Prevention Programme; however, the adverse event incident form

records: "Action taken at the time of incident was appropriate except not reported to RN. This has been discussed with staff involved." The issue of reporting incidents to the registered nurse was also discussed at the team meeting on 29 Month4. The fall was not reported to Mr B's family until 29 Month4, five days after the fall.

92. On 20 Month5, Mr B had another unwitnessed fall. This was reported to RN F, and neurological observations were taken in accordance with his instructions. The rest home was in contact with the family over the next seven days, but there is no record of the family being informed of the fall. The event incident report shows that the fall was not notified to the CNM.

93. I am concerned that the first fall was not reported to the registered nurse, and there was a delay in notifying the family. The second fall was reported to the registered nurse, but the CNM and Mr B's family were not informed.

Pressure injury management

94. On 19 Month5, an STCP was put in place by RN F for a pressure injury on Mr B's left heel. Daily measurements and dressing changes were undertaken by various registered nurses up to and including 23 Month5. On 23 Month5, the pressure injury had reduced in size and there was no sign of infection. However, there was no staging information of the injury, no photographs were taken, and no pressure-relieving measures were recorded. There were no more entries on the STCP after 23 Month5.

95. On 25 Month5, Dr E assessed Mr B at RN C's request, but there is no mention of Mr B's pressure injuries. RN C started another STCP that day, as Mr B had begun to develop other pressure injuries to his sacrum, hips, and toes. The plan specified pressure-relieving methods to be taken, including two-hourly change of position when in bed, but there was no information regarding staging of the injury, and no photographs were taken.

96. There is no record that the STCP of 25 Month5 was implemented by staff. Mr B's position in bed was meant to be changed every two hours, but on the night of 25 and 26 Month5 there is no record of his position having been changed. Regarding the night of 26 Month5, RN C told HDC:

> "In his frail condition, this amount of time in one position would be enough to ensure swift deterioration of his pressure injuries."

97. There is no record that the dressing on Mr B's left heel was changed after 23 Month5, despite a change being due on 25 Month5, and oozing from the wound on the evening of 26 Month5. I note the comment by my clinical advisor, RN Russell:

> "It seems unlikely that a dressing that was done daily could be missed for 4 days — however from the documentation it appears this was what occurred."

98. Mr B was transferred to Facility 2 on 27 Month5, and the dressing was not changed prior to his discharge. RN C notes in her Month6 review that "there was no note of this [oozing] on the handover sheet to alert RN to this".

99. RN C acknowledges that the documentation by the healthcare assistants at this time was limited. She told HDC: "[W]e cannot be certain that this last STCP was completely followed." RN Russell stated:

> "Nursing documentation is what is relied on to record day to day changes and plans of care, it is imperative that nursing staff get this right."

100. I agree that documentation is crucial for supporting continuity and quality of care, and I am critical of the standard of documentation in the last week of Mr B's stay at the rest home.

101. I acknowledge that staff at the rest home had previously healed a pressure injury on Mr B's left heel in Month1, and that the left heel injury identified on 19 Month5 was reducing in size on 23 Month5. However, I agree with my clinical advisor that Mr B's STCPs in Month5 were not comprehensive in all aspects of pressure injury management. I am concerned that staff did not access external health professionals for advice on the pressure injuries, as outlined in the rest home's Pressure Injury Prevention Policy.

102. I am very concerned about the following omissions in Mr B's pressure injury management by various nursing staff:

- Mr B's family were not informed about the state of his pressure injuries.
- The 19 Month5 STCP contained no information regarding staging of the injury, no photographs were taken, and no relieving measures were recorded.
- There were no entries on the 19 Month5 STCP after 23 Month5.
- The 25 Month5 STCP contained no information regarding staging of the injury, and no photographs were taken.
- The 25 Month5 STCP was not implemented by staff. Mr B's position in bed was not changed during the nights of 25 and 26 Month5.
- There was limited documentation by various staff on 25 and 26 Month5.
- Dr E was not made aware of the pressure injuries when he reviewed Mr B on 25 Month5.
- There is no evidence that the dressing on the left heel pressure injury was changed after 23 Month5, despite a dressing change being due on 25 Month5, and oozing the night before the transfer to Facility 2 on 27 Month5.
- Mr B's pressure injury risk had not been formally assessed since 20 Month1.
- The written notes did not match the codes selected in the interRAI reassessment of 20 Month5.

103. I note that in Month6, the DHB completed an investigation into lapses in documentation of Mr B's pressure injuries at the rest home. The DHB made a number of recommendations

regarding discharge and handover, interRAI training, and pressure-relieving resources, which the rest home has actioned. These actions were appropriate.

Transfer to Facility 2

104. Mr B's transfer to Facility 2 occurred on the morning of 27 Month5, following the decision to transfer on 26 Month5. The rest home acknowledges that it did not follow the Discharge/Transfer Policy for Residents, as no written handover was provided to Facility 2. RN C commented that "[t]he short time-frame from assessment to discharge did not give adequate time to follow the policy in [Mr B's] case".

105. I note that RN C conducted a review in Month6, and that as a result, all discharged residents are provided with a full written handover as well as a verbal handover to the receiving facility, and that discharges are now planned with a time-frame that is comfortable for the family and gives the rest home time to ensure that it can follow the Discharge/Transfer Policy for Residents.

106. Verbal handover was given to Facility 2; however, RN Russell advised that it would have been better practice for RN C to call Facility 2 with an update, given Mr B's considerable decline over the 12 to 24 hours before transfer. Information regarding the extent of Mr B's pressure injuries was not handed over to the new facility. RN Russell stated: "[Facility 2] would have been expecting a resident different to the one they received on the 27 [Month5] when he was transferred."

107. I agree with RN Russell's advice, and am critical that the transfer to Facility 2 was not documented adequately, and the extent of Mr B's pressure injuries was not communicated to Facility 2.

Communication with family

108. There were lapses in communication with Mr B's family in Months 4-5, particularly in the last week before his transfer to Facility 2. When Mr B had a fall on 24 Month4, his family were not informed until five days later, on 29 Month4. After Mr B's fall on 20 Month5, the family contact sheet records three conversations with Ms D — on 21, 24, and 25 Month5 — but there is no record of having informed the family of Mr B's fall, and thus the family was not given the opportunity to advocate on his behalf. I note Mrs A's comment that the family "would have insisted on X rays". The Falls Prevention Programme at the rest home states that "[r]esidents family (Next-of-kin/EPOA) must be notified of all resident falls".

109. RN Russell commented that despite the considerable amount of communication between Mr B's daughter and the rest home regarding Mr B's general health, the family were not informed of Mr B's pressure injuries or the second fall. RN Russell advised:

> "Not providing notification of falls in a timely manner and information regarding the pressure injuries are considered as severe departures from accepted standards of care.
>
> …

> The lack of open disclosure regarding these two aspects of [Mr B's] care leave it open to interpretation that [rest home] staff are purposely withholding information. This is disappointing as it appears that prior to these events [the rest home] had an otherwise open and communicative relationship with [Mr B's] family."

110. I agree that this is not the accepted standard of care.

111. I am very concerned about the rest home's lack of communication with Mr B's family regarding his falls and pressure injuries. Mr B's family were very involved in his care, and would have expected this pertinent information about his health to be conveyed to them. RN C acknowledged that "there was a gap in communication with the family". I consider that information pertaining to a change in health condition, such as falls and pressure areas, is significant, and information that a family would expect to receive. I am critical that this did not occur.

Conclusion

112. In my view, G J & J M Bellaney Limited had the ultimate responsibility to ensure that Mr B received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). RN C acknowledges that there were "deficits in [Mr B's] care in the last 24 hours of his stay at [the rest home]". My clinical advisor, RN Russell, has advised that there were a number of departures from the accepted standard of care by the rest home. RN Russell stated:

> "For the future G J & J M Bellaney Limited may consider gaining access to a more speciali[s]ed level of nursing such as a Clinical Nurse Specialist or Nurse Practitioner as it appears that [Mr B] would have benefited from a comprehensive nursing assessment that would have included a review of the pressure areas, mobility etc."

113. I consider that there were deficiencies in the care provided to Mr B by multiple staff at the rest home in Months 4-5, but in particular in the period leading up to his transfer to Facility 2 on 27 Month5. In my view, these were systemic issues for which G J & J M Bellaney Limited bears responsibility. As outlined in detail above, the following issues occurred in the care provided to Mr B in the following areas:

- Communication of falls and pressure injuries
  - The fall on 24 Month4 was not reported to Mr B's family until 29 Month4.
  - The fall on 20 Month5 was not reported to Mr B's family.
  - The state of his pressure injuries was not reported to Mr B's family.
  - Dr E was not made aware of the pressure injuries when he reviewed Mr B on 25 Month5.
  - The extent of Mr B's pressure injuries was not communicated to Facility 2. The verbal handover needed to be updated given Mr B's considerable decline in the 24 hours prior to transfer.

- Management of pressure injuries
  - Mr B's pressure injury risk had not been formally assessed since 20 Month1.
  - The 19 Month5 STCP had no information regarding staging of the injury, no photographs were taken, and no relieving measures were recorded.
  - There were no entries on the 19 Month5 STCP after 23 Month5.
  - The 25 Month5 STCP had no information regarding staging of the injury, and no photographs were taken.
  - The 25 Month5 STCP was not implemented by staff. Mr B's position in bed was not changed during the nights of 25 and 26 Month5.
  - There is no evidence that the dressing on the left heel pressure injury was changed after 23 Month5, despite a dressing change being due on 25 Month5, and oozing the night before the transfer to Facility 2 on 27 Month5.
- Documentation
  - There was limited documentation by various staff on 25 and 26 Month5.
  - The written notes did not match the codes selected in the interRAI[16] assessment of 20 Month5.
  - No written handover was provided to Facility 2 on transfer.

114. In light of these issues, I consider that the care provided to Mr B by G J & J M Bellaney Limited was inadequate, and resulted in Mr B's pressure injuries not being well managed, Mr B's family not being kept informed, and the DHB and HealthCERT being notified of Mr B's pressure injury only after he was transferred from the rest home. Accordingly, I find that G J & J M Bellaney Limited did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.[17]

Opinion: RN C — adverse comment

115. RN C is the Clinical Nurse Manager at the rest home. Her job description states that she is "to oversee all aspects of clinical management in [the rest home]" and "[e]nsure that the care provided by other members' of [the rest home's] nursing and care giving staff are of a high standard and in keeping with current best practice".

[16] A suite of seamless and comprehensive clinical assessment instruments, developed by an international collaborative to improve the quality of life of vulnerable people.
[17] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

116. As the CNM:

> "[RN C is] to ensure that all residents' health requirements are maintained. The CNM is expected to at all times have an overall review of all residents' wellbeing and to give guidance and assistance, as necessary, to other staff on how to ensure residents' wellbeing."

117. RN C's job description also includes a section on communication, which states:

> "Each resident's family/whanau and POA are to be communicated with by the CNM in the event of any significant changes to a resident's status e.g.: deterioration in behavio[u]r or health. They must also be involved in any significant changes around a residents care e.g.: the need for transfer within the facility or externally."

118. I am concerned that RN C provided insufficient monitoring and oversight of aspects of Mr B's care, particularly in the last 24-hour period of Mr B's stay at the rest home, when Mr B's pressure injuries deteriorated rapidly. There was also a lack of monitoring and oversight in the last week of Mr B's stay. This included that the STCPs dated 19 and 25 Month5 were not comprehensive in all aspects of pressure injury management, the 19 Month5 STCP contained no entries after 23 Month5, and there was no evidence that the left heel dressing was changed from this date, the 25 Month5 STCP was not implemented by staff, and documentation was limited. RN C was not notified of Mr B's fall on 20 Month5, and did not review the adverse event incident form until 4 Month6. This resulted in the family not being informed of the fall in a timely manner.

119. In addition, when Mr B was transferred to Facility 2 on 27 Month5, RN C provided verbal handover but no written handover. I also note that there were issues with the interRAI reassessment of 20 Month5, as the written notes made by RN C did not match the codes selected. I consider that as the CNM it was RN C's responsibility to manage the smooth transfer of care to Facility 2. It was also her responsibility to ensure that the care provided by staff at the rest home was of an appropriate standard in Months 4-5, and to ensure that Mr B's family were informed of any falls and pressure injuries.

120. I note that RN C had additional training on interRAI on 20 Month7, and as the Clinical Nurse Manager she now ensures that resident discharges are planned with a time-frame that allows for a full written handover as well as a verbal handover to the receiving facility. These actions are appropriate.

121. In summary, there is evidence of RN C being very involved in Mr B's care, and she was alert to his deteriorating health. There was a considerable amount of communication between Mr B's family and RN C regarding his general health. There is also evidence of RN C addressing quality issues as they arose at the rest home. After reviewing the incident form following the fall on 24 Month4, RN C notified the family and took steps to give guidance to staff, including discussing issues with the staff involved, and discussing the issues at the team meeting on 29 Month4. However, the deficiencies in the care provided to Mr B relate to the failings of various staff, and I am critical that RN C did not provide sufficient overall

review of Mr B's care, particularly in the last few days of his stay at the rest home when his pressure injury deteriorated rapidly within a short timeframe.

Recommendations

122. I recommend that G J & J M Bellaney Limited:

a) Provide a formal written apology to Mr B's family for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Consider gaining access to a more specialised level of nursing such as a Clinical Nurse Specialist or Nurse Practitioner, and provide HDC with an update on its decision.

c) Clarify guidelines and agreed protocol for accessing specialist advice, be it from a GP, a clinical nurse specialist, or the DHB wound service.

d) Schedule regular and ongoing education sessions for all the rest home nursing staff on the following topics:

   i Pressure area prevention and management, to include staging of injuries

   ii Falls management

   iii Short Term Care Plans

   iv Transfer/discharge of residents

   v Communication with residents' next of kin

   vi Open disclosure

   vii Pain management.

e) Use an anonymised version of this report as a case study, to encourage reflection and discussion during the above education sessions.

f) Provide HDC with an update in relation to the effectiveness of the changes made following these events. As part of this, the rest home is to provide this Office with the last audit undertaken in relation to:

   - STCPs for managing pressure injuries and staff documentation of this.
   - The communication of falls and pressure injuries to residents' family.
   - Compliance with the Discharge/Transfer Policy for Residents regarding written handover to the receiving facility on the discharge/transfer of a resident.

The information requested in points (b) to (f) above is to be provided to HDC within three months of the date of this report.

Follow-up actions

123. A copy of this report with details identifying the parties removed, except G J & J M Bellaney Limited and the expert who advised on this case, will be sent to the DHB, the Ministry of Health (HealthCERT), and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following clinical advice was obtained from RN Julia Russell:

"6 May 2019

Re: [Mr B] C18HDC01024 (dec) formerly of [the rest home] and [Facility 2].

Documents that were provided for review included:

- Letter of complaint dated […].
- [The rest home's] response dated 6 July 2018; this was a copy of a report written to ACC treatment injury notification of harm report provider feedback which follows up the 13 [Month6] review of notes relating to pressure injury
- [Facility 2's] response dated 2 July 2018.
- Clinical records from [the rest home].
- Clinical records from [Facility 2].

The purpose of this report is to comment on:

1. [The rest home's] appropriateness of the assessment of [Mr B] following his fall on 24 [Month4] and the reporting of [Mr B's] fall. Further to comment on the appropriateness of the monitoring and management of [Mr B's] pressure injuries.
2. [Facility 2] and the appropriateness and treatment of [Mr B's] pressure areas there.

This report does not cover [Mrs A's] concern regarding the care at [Facility 2] and the follow-up regarding the pain experienced on transfer and movement and that there was an underlying hip fracture that had occurred — possibly at [the rest home] but was not detected and therefore not treated.

Overview of [Mr B's] care

[Mr B] had been a resident at [the rest home] since [2015]. In the months of [Months 4-5] his health significantly deteriorated to the extent that on the 27 [Month5] he was transferred to a hospital level of care at [Facility 2]. The transfer occurred very quickly — the day after the assessment was done.

In their reports of 6 July 2018 and 13 [Month6] [the rest home] provide[s] a thorough overview of the notes and events of the time of that deterioration. The 2 July 2018 document confirms the actions undertaken by [the rest home]. Included in this material was a letter from [RN C] who was the Clinical Nurse Manager at the time apologizing for the inadequate care provided.

Key points:

- [Mr B's] family had been in regular contact with the staff at [the rest home] regarding his care. [Mr B] had 2 falls 24 [Month4] and 20 [Month5]. Mobility after the first fall did decline despite the RN assessment not identifying any acute issues.

- Prior to [Mr B's] transfer there was a considerable amount of communication between the daughter and [the rest home] regarding his general health however none of the information was shared about the pressure injuries he had and the continuing deterioration of these. Given this contact it is surprising the pressure injury information was not shared. A lengthy conversation is recorded on the 27 [Month5] however there is no discussion regarding dressings etc.
- The fall of the 20 [Month5] — at the time of his fall Family were not advised of the fall. The call was made to family by [RN C] CNM 5 days later on the 29 [Month5].
- There are short term care plans (STCP) written for pressure injuries — however no photos were taken
- 19 [Month5] — a STCP is written for the L heel pressure area.
- 25 [Month5] — a further STCP was detailed on the injuries including a pressure area on the sacrum and issues on toes on both feet showing signs of pressure. There are no measurements of the wounds. This STCP has only one recording on the 27 [Month5] noting the toes seem better — the hip (not previously mentioned) and the sacrum were deteriorating. This is the day that [Mr B] was transferred to [Facility 2].
- These STCPs were not comprehensive in all aspects of pressure injury management and provide no information regarding the staging of the injuries. Wound measurements were not taken and [RN C] comments that she felt there was some improvement when she reviewed it and did a new STCP on the 27 [Month5]. There are no comments regarding the dressings in the daily progress notes. There are comments that he is having trouble standing and that will be related to the dressings on his feet. It seems unlikely that a dressing that was done daily could be missed for 4 days — however from the documentation it appears this was what occurred.
- On the day of the transfer to [Facility 2] there was no written transfer/discharge of Residents and there was no paperwork sent with [Mr B] — this meant that the extent of the wounds was not known to them.

[The rest home's] policies regarding Pressure Injury Prevention Policy and Wound and Skin Management Policy are adequate. However, the care provided to [Mr B] did not meet the accepted standard of care in the area of monitoring the falls and the management of the wounds — sacral pressure sore, pressure areas on the toes on both feet and also on the hip.

The expected standard of care includes notification of family regarding the falls and the management of the pressure injuries. On the STCP the injuries do appear to have been improving however there is a gap in information and the appearance of them at [Facility 2] suggests they were not improving. The lack of open disclosure regarding these two aspects of [Mr B's] care leave it open to interpretation that [the rest home] staff are purposely withholding information. This is disappointing as it appears that prior to these events [the rest home] had an otherwise open and communicative relationship with [Mr B's] family.

Not providing notification of falls in a timely manner and information regarding the pressure injuries are considered as severe departures from accepted standards of care. [The facility] is a rest home and as such may not have access to that level of specialized nursing skill to assess residents of [Mr B's] complexity. For the future they may consider gaining access to a more specialized level of nursing such as a Clinical Nurse Specialist or Nurse Practitioner as it appears that [Mr B] would have benefited from a comprehensive nursing assessment that would have included a review of the pressure areas, mobility etc.

2. [Facility 2] and the appropriateness and treatment of [Mr B's] pressure areas there.

[Mr B] was transferred to [Facility 2] on the 27 [Month5]. It is not clear if the admitting staff member was aware of the pressure injuries as there is no comment about them. A full review of the existing areas was done on the 28 [Month5] with Section 31 for the Ministry of Health being completed as well as wound assessment charts with dressing details and photographs were taken (and shared with [the rest home]). Plans to manage the pressure injuries were initiated including a pressure relieving mattress, pressure area boots and food supplements to improve [Mr B's] nutritional status.

In the [Facility 2] material there are faxes and documentation to the General Practitioner that indicate good processes and assessment. [Mr B's] weight had declined so the RN requested a special authority so that high protein drinks could be obtained. The progress notes describe:

- Interactions with Family regarding [Mr B's] health status and actions including the charting of end of life medications, family discussions are well documented. It is evident in the notes that [Mr B] is declining rapidly and that he is at the end of his life
- Input from [the hospice] confirming the actions that were being undertaken by [Facility 2] and General Practitioner
- Input from the Clinical Nurse Specialist Tissue Viability initially as a phone consultation on the 4 [Month6] and confirming the actions of [Facility 2 staff] in managing the pressure injuries [Mr B] had. This Clinical Nurse Specialist visited on the 11 [Month6] and 19 [Month6] again reaffirming the staging of the injuries and that they had improved from the initial photographs taken.

[Mr B] died [in Month7].

The care provided by [Facility 2] staff meets the accepted standard of care in the management of the wounds of the pressure injuries. They involved a Clinical Nurse Specialist in the review and further treatment who reported an improvement which given [Mr B's] state of health is reflective of the high standard of care. …

Julia Russell, RN M Phil (Nursing)"

Further clinical advice

The following further advice was received from RN Russell:

"**Report re: [Mr B] (dec) C18HDC01024**

This report is a follow up to the 6 May 2019 report regarding the care and support of [Mr B] at [the rest home] [from his admission in 2015] to 27 [Month5]. The purpose of this follow up report is to determine if the original advice would change as a result of additional information provided. The further information included:

1. Letter from [Mrs A], [Mr B's] daughter providing her further response to a report from [the rest home].
    a. [Mrs A's] letter describes further issues [Mr B's] family experienced. These further issues highlight the difficulties in managing care for the frail elderly and the use of equipment such as sensor mats. Equipment management is planned by senior staff but is reliant on staff utilizing the equipment which is not always understood as a priority in the midst of heavy workloads.

2. Letter from HealthCERT stating there have been no issues raised regarding [the rest home].
    a. As part of this review the 2018 audit report was made available, earlier ones which are on the Ministry of Health's website were also reviewed. The 2016 Certification Audit identified a low risk finding around the management of short-term care plans which was documented as having been fully resolved in January 2017.

3. 17 July 2019 letter from the Ministry of Health stating there had been no complaints about [the rest home] and the most recent audit had no findings.

4. 21 June and 5 July 2019 letters from [the DHB].
    a. This letter detailed their investigation of the matter and provided the following recommendations regarding discharge issues and handover

An investigation was initiated from DHB and completed on 2017 which identified a number of lapses. The following recommendations were made:

- Review and update, if required, pre-discharge nursing assessment documentation
- Review and update, if required, pre-discharge documentation processes
- Develop processes to ensure that pressure relieving mattresses and other resources are available when needed
- Ensure that the Facility Manager undertakes an InterRAI update which includes coding, significance of outcome scores and consistency with coding and notes
- That all staff receive in-service on communication processes particularly handover, and discharge documentation.

As the concern was substantiated following investigation it was also notified to HealthCERT.

5. 17 July 2019 letter from [RN C], the [the rest home's] Clinical Manager.

   a. In this letter [RN C] responds to 6 points from the 6 May 2019 report, in this she concurs with the findings regarding communication with [the family] from the 6 May 2019 report. Point 3 page 1 and point 4 page 2. [RN C] identifies [Mr B's] pressure injuries were being treated and monitored and provides a 19 [Month5] STCP. The 6 May 2019 report notes the existence of the 19 [Month5] STCP however, this was not provided as part of the original material, therefore the information regarding the measurements was not referred to in the initial report. [RN C] notes that the 19 [Month5] STCP shows the heel wound was improving given the smaller measurement (on the 19–22 [Month5] it was 2 x 3cm on the 23 [Month5] it was recorded as 2x2 cm, the area around it was also ticked as inflamed). Whilst the wound measurements are on the 19 [Month5] STCP there was no information regarding staging of the injury. The L heel dressing was last done on the 23 [Month5] and was then due every second day which means it should have been done on the 25 [Month5] (it does not appear to have occurred). [Mr B] left [the rest home] on the morning of the 27 [Month5] so that would explain why it was not done that day. The [Month1] STCP provided confirms [RN C's] comments that [the rest home] has a record of healing wounds.

      The STCP completed on the 25 [Month5] assists in gathering the information about [Mr B's] then state of health and was an opportunity to discuss his declining health and supported his pending transfer to a higher level of care. As [RN C] acknowledges her second point 1 page 1 there are gaps in the recording of these wounds and communication with the family. This means the family received information regarding [Mr B's] wounds at [Facility 2] which is not the expected standard of care. As noted by [RN C] information is available to a new provider on InterRai and Medimap. The [Facility 2] staff recorded in [Mr B's] notes that Medimap was not immediately available. InterRai information may have been available prior to the transfer but would have been transferred to the new provider on the day of the transfer. As the InterRai would have been

> completed prior to the change in level of care it would not have captured the further deterioration over the 24 hours prior to [Mr B's] transfer. [Facility 2] would have been expecting a resident different to the one they received on the 27 [Month5] when he was transferred. Verbal handover was given to a [Facility 2] staff member by [RN C] sometime after [the NASC] assessment was done on the 26 [Month5]. However, given the considerable decline over the 12–24 hours [RN C] refers to, better practice would be for [RN C] to call [Facility 2] to update them about this.

[Mr B] was clearly very frail by [Month4] and had declined rapidly throughout that time. As noted in the 6 May 2019 a comprehensive nursing assessment which would consider all elements of [Mr B's] care and health would have been of benefit and it is not clear if [the rest home] had access to an appropriate nurse specialist for this. Nursing documentation is what is relied on to record day to day changes and plans of care, it is imperative that nursing staff get this right. From the documentation and the audit reports it is clear [the rest home] has done a significant amount of work to improve their service. However, the new material provided does not alter that there were wounds present and the family were not aware of the extent of them which demonstrates severe departures in the standard of care in the communication with the family. The 19 [Month5] STCP shows that there was documentation around the heel wound and a plan of care had been done with measurements which is an improvement to the initial findings of the 6 May 2019 report. However, the completion of the 25 [Month5] STCP identifying new wounds which were not communicated to the family is a missed opportunity. Further to this the information regarding the extent of the wounds was not handed over to the new facility. Given the new material provided there is no change from the advice regarding these wounds and communication regarding these continues to be a severe departure from the expected standards of care as it was in the 6 May 2019.

…

Julia Russell RN, M Phil (Nursing)"