# A Rest Home

## A Report by the

## Health and Disability Commissioner

## (Case 02HDC18190)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

## Parties involved

| | |
|---|---|
| Mr A | Consumer |
| Ms B | Consumer's daughter/Complainant |
| Ms C | Consumer's daughter/Complainant |
| Ms D | Consumer's daughter |
| Ms E | Consumer's granddaughter |
| Ms F | Consumer's daughter |
| Dr G | Provider/General Practitioner |
| Ms H | Provider/ Manager at the rest home |
| Dr I | General Practitioner |
| Dr J | Consultant geriatrician |
| Dr K | Neurologist |
| Dr L | General Practitioner mental health assessment team for the elderly |
| Dr M | Consultant radiologist |
| Mrs N | Director of Aged Care Services at the rest home |
| A Rest Home | Provider/Rest Home |
| A Retirement Village | Retirement Village |

## Complaint

On 4 December 2002 the Commissioner received a complaint from Ms B about the standard of care provided by Dr G and a rest home.. The complaint was summarised as follows:

**Dr G**

*Dr G did not provide services of an appropriate standard to Mr A while he was at the rest home.*

*Dr G:*

- *did not adequately review or treat Mr A's bedsore, and in particular:*
  - *did not examine his bedsore until 4 October 2002, despite having prescribed antibiotics for it in early August when the skin had already broken down;*
  - *did not seek hospital admission or specialist review for Mr A regarding his bedsore;*
- *did not appropriately manage Mr A's medication;*
- *did not appropriately review Mr A after falls in August and September 2002 and diagnose that he had broken ribs.*

*Dr G did not keep Ms C, who held Mr A's enduring power of attorney, fully informed. In October 2002 Dr G:*

- *did not inform Ms C that she had examined Mr A's bedsore on 4 October 2002 and found that it had developed into a smelly six-centimetre crater;*
- *did not inform Ms C, after examining Mr A on 14 October 2002, that he was deteriorating, and that the wound had extended in size;*
- *did not inform Ms C at a meeting on 21 October 2002 to discuss Mr A's condition that Mr A's bedsore had deteriorated and that she had recently prescribed him antibiotics;*
- *did not explain to Ms C at the meeting on 21 October that Mr A's broken ribs and deteriorating bedsore may have contributed to his general decline over the previous three weeks;*
- *while discussing treatment options for Mr A, did not inform Ms C that a specialist neurologist had recommended Mr A be admitted to hospital.*

**The Rest Home and Ms H, Nursing Manager**

*Ms H and staff at the rest home did not provide services of an appropriate standard to Mr A in that they:*

- *did not adequately review Mr A's bedsore, and in particular:*
  - *did not arrange appropriate medical review for Mr A;*
  - *did not arrange for a specialist wound care nurse to review Mr A;*
- *did not adequately treat Mr A's bedsore, and in particular:*
  - *did not provide Mr A with a pressure-relieving mattress;*
  - *did not use appropriate medication and dressings to treat the bedsore;*
  - *placed Mr A in a wheelchair for extended periods;*
  - *encouraged Mr A's family to sit him in a wheelchair while he had a severe wound on his sacrum;*
- *did not appropriately manage Mr A's medication;*
- *did not take adequate precautions to prevent Mr A injuring himself;*
- *did not ensure Mr A was reviewed by a doctor, until two days after a fall on 19 August 2002;*
- *did not appropriately document the injuries to Mr A's ribs;*
- *on 27 October 2002:*
  - *did not provide Mr A with oxygen despite his distress, breathlessness and blue colour;*
  - *did not seek prompt medical assistance for Mr A despite his clear respiratory distress;*
  - *did not promptly call an ambulance for Mr A despite his increasing respiratory distress.*

*Ms H and staff at the rest home did not keep Ms C, who held Mr A's Enduring Power of Attorney, fully informed. In particular:*

- *they did not inform Ms C of the severity and deteriorating nature of Mr A's bedsore;*
- *on 17 October 2002, the Nursing Manager, Ms H, incorrectly informed Ms C that Mr A's bedsore was progressing well.*

An investigation was commenced on 17 March 2003.

## Information reviewed

- Letter of complaint, dated 1 December 2002, including photographs of Mr A's sacral wound

- Further information provided by complainants, including Mr A's enduring power of attorney in relation to personal care and welfare

- Letter of notification, dated 17 March 2003

- Response from Dr G, dated 25 March 2003, including:
  - Mr A's notes, from 24 January 2001 until 13 November 2002
  - Note of conversation, dated 21 October 2002
  - Doctor's Progress Notes from the rest home
  - Notes from the DHB, dated 8 November 2002
  - Case review from the DHB, dated 12 November 2002
  - Letter to Dr G from Dr J, dated 11 September 2002
  - Letters to Dr I from Dr K, dated 21 March and 24 July 2002
  - Letter to Dr K from Dr L, dated 9 August 2002
  - Letter to Dr I from […], dated 29 August 2002
  - Letters to Dr G from Ms B, dated 27 June, 7 and 24 July and 7 August 2002

- Response from the rest home, dated 7 April 2003, including:
  - Doctor's Progress Notes
  - Medication Sheet
  - Wound Care Policy
  - Resident Lifestyle Care Plan
  - Specialised Plan of Care
  - Short Term Problems – Management Plan
  - Braden Scale Policy
  - Wound Care Forms, dated 9 and 20 August and 2, 15, 19 and 23 September 2002
  - Wound Care Assessment Charts, dated 1, 6, 13, 14, 20, 24 and 26 October 2002
  - Daily Nursing Reports, from 23 August to 22 October 2002 (incomplete)
  - Accident Incident Report, dated 19 August 2002
  - Consent Form
  - Physical Restraint consent form
  - Information on pressure relieving mattresses
  - Photographs of chair

- Further responses from the rest home, received 12 May and 17 July 2003, which provide a full copy of the Daily Nursing Reports

- Information provided by the DHB, dated 9 May 2003, including:
  - Photographs of sacral wound
  - Mr A's medical records

- Responses to my provisional opinion from:
  - The rest home, dated 19 April 2004, including an apology to the family of Mr A, updated policies and other documentation
  - Ms B, dated 15 April 2004, 14 May 2004, 16 August 2004, 2 October 2004, 6 October 2004 and 1 December 2004, including information about medication and the prevention and care of pressure wounds; photographs of Mr A, his bed and his wheelchair; an opinion from a consultant radiologist on Mr A's chest X-ray; a copy of the rest home Code of Residents' Rights and Responsibilities; excerpts from Mr A's medical records; and information about pressure-relieving mattresses
  - Ms D, dated 15 April 2004
  - Ms E, dated 16 April 2004
  - Letters from lawyers, on behalf of the family, dated 28 February and 22 March 2005

- Responses to my second provisional opinion from:
  - The rest home, dated 20 May 2005
  - Ms B, dated 25 May 2005 including sworn statements from Ms F (dated 25 May 2005), Ms D (dated 24 May 2005), Ms C (dated 25 May 2005) and Ms B (dated 24 May 2005).

Independent expert advice was obtained from Dr Keith Carey-Smith, general practitioner, and Ms Jan Featherston, registered nurse.

## First provisional opinion and mediation

On 24 March 2004 I sent the parties copies of my first provisional opinion, in which I set out my provisional view that Dr G and Ms H had not breached the Code of Health and Disability Services Consumers' Rights ("the Code"). I considered that the rest home ("the rest home") had breached the Code in relation to its treatment of Mr A's sacral wound and the management of his medication. I proposed to take no further action in relation to communication issues, owing to evidential conflicts, and did not consider the rest home to have breached the Code in any other respect.

Upon receiving responses to my first provisional opinion I formed the view that a mediation conference would be an appropriate means of resolving this complaint. After some discussion the parties agreed to attend a mediation conference. The conference took some

time to organise because of the number of parties involved, and eventually took place on 5 November 2004. The mediator reported to me that a "good closure" was reached between the family and Ms H and Dr G. Only a partial closure was reached between the family and the rest home, and the mediation conference was adjourned with discussions continuing between the remaining parties and their representatives until 15 December 2004, at which point resolution had not been achieved.

Thereafter, having reviewed the entire file, I decided (on the basis of all the available information and the settlement agreement from the mediation conference) to take no further action on this complaint insofar as it relates to Dr G and Ms H. I informed the parties of this decision on 22 December 2004. I then proceeded to review the responses to my first provisional opinion in relation to the family's complaint about the rest home. Those parts of the complaint that relate to Dr G are not addressed in this opinion. While I have taken no further action on the complaint as it relates to Ms H, her actions as an employee of the rest home have been considered and taken into account in reaching my opinion on this part of the complaint.

## Second provisional opinion

On 28 April 2005 I sent the parties copies of my second provisional opinion, in which I set out my further provisional view that the rest home had breached the Code in relation to its treatment of Mr A's sacral wound and the management of his medication. On the basis of the responses to my first provisional opinion I also formed the provisional view that the rest home had failed to document injuries Mr A sustained and had provided insufficient information to Ms C (the holder of his enduring power of attorney). I proposed to take no further action in relation to whether the rest home inappropriately treated Mr A's bedsore by placing him in a wheelchair for extended periods, owing to evidentiary conflicts, and did not consider the rest home to have breached the Code in any other respect.

## Information gathered during investigation

*Admission to the rest home*
On 25 May 2002, Mr A (aged 72 years) was admitted to the rest home from his previous care facility, a retirement village. The discharge summary from the retirement village records that Mr A had received no wound dressings. Ms H (the rest home's manager) stated that on admission, staff noted that he had a small reddened sinus (hollow or cavity) above his coccyx, although the sinus was not recorded in the notes provided by the rest home. Mr A was admitted with a clinical history of Parkinson's disease, moderately severe dementia, constipation and double incontinence. Ms B advised that her father also had spinal stenosis

and wasting of the left leg. He required full-time hospital level care. According to Dr G, the GP who later took over Mr A's care, Mr A appeared to have deteriorated rapidly over the preceding 12 months although his family advised that he was still farming until October 2001.

The admission procedure at the rest home included establishing who to consult in relation to Mr A's care. Two of Mr A's daughters, Ms C and Ms D, signed a "Consent Form" on Mr A's behalf (as he was unable to sign himself), which authorised their being given information about his care. They also signed the rest home "Code of Residents' Rights and Responsibilities" (which essentially replicates the Rights set out in the Code).

Ms C states that in late May she informed Ms H that she held an enduring power of attorney for Mr A's personal care and welfare, although this had not yet been activated. Ms H states that she never viewed this document.

On 28 May, the rest home performed a risk assessment for pressure sores using the Braden scale. Mr A's score was 21, indicating that he had only a minimal risk of developing pressure ulcers and that no extra precautions were required. This conflicts with Mr A's Resident Lifestyle Care Plan (undated) on which staff had noted a "score" of 17 and a risk level of "high".[1] The Resident Lifestyle Care Plan noted the goal of maintaining skin integrity and monitoring pressure areas. An assessment to predict fall risk was also carried out and Mr A scored 26, which indicated that he had a high risk of falling (a score of 27 was noted on the Resident Lifestyle Care Plan). The corresponding goals in the Resident Lifestyle Care Plan were to allow Mr A time to get his balance when standing up, having two people assist in moving him, and to use a walker or wheelchair.

*Deterioration and medication issues*

Over the first month of Mr A's stay at the rest home his condition deteriorated. He was experiencing some psychosis, agitation and confusion. Mr A became more suspicious, uncooperative and aggressive towards staff and residents, his sleeping habits were poor, staff were unable to keep him off his back at night, his mobility decreased and he was having difficulty swallowing. He was given a sedative (temazepam, which had been prescribed for use as required) at night to help him sleep.[2] According to Ms D, it was the deterioration over this period that prompted the family to request an urgent review of his medication.

In Ms B's opinion, her father's mental state was severely affected by the side effects of his medication, particularly the abrupt cessation of pergolide on 15 May 2002, just prior to his

[1] The lower the score on the Braden scale, the higher the risk of a pressure sore developing.

[2] The medication sheet for temazepam appears to have been filled in by Mr A's GP, Dr I. There is no signature next to this item but the writing is the same as other entries on the sheet for the same date, which were signed.

admission.[3] She states that at the time of his admission he had severe symptoms such as hallucinations that insects were crawling all over his body. The *New Ethicals Compendium* states that the abrupt discontinuation of pergolide may cause such hallucinations and confusion.[4]

On 5 June Mr A was reviewed by his GP, Dr I. She noted that he was alert and orientated but that he had occasional confusion associated with his Parkinson's disease, which could also be medication related. The rest home nursing notes also indicate that on 13 June one of Mr A's daughters had queried whether the temazepam was contributing to his confusion, and there is a request that staff observe whether this was so. Later in June Dr I went on maternity leave, and her partner, Dr G, took over Mr A's care. Prior to going on maternity leave, Dr I had arranged for Mr A to be reviewed by Dr K (a neurologist) for a "follow up of Parkinson's disease".

Dr G reviewed Mr A twice in June. In a letter to Dr G dated 27 June Ms C noted that her father was very depressed and had become very aggressive and paranoid with the staff. She queried who he could be referred to and whether a referral could be hastened. In this letter Ms C also requested that Dr G assess Mr A to ascertain whether the enduring power of attorney should be activated. Ms B informs me that Ms C also spoke to Dr K requesting a referral to Dr L (a doctor from the mental health assessment team for the elderly) to address the family's concerns about Mr A's medication issues.

In Dr G's opinion there were a number of reasons for Mr A's deterioration, including cognitive impairment due to dementia associated with his Parkinson's disease, being unsettled by the move to the rest home, separation from his wife, and possibly his Parkinsonian medication. She felt that it was "largely an acute stress reaction" and on 20 June prescribed lorazepam[5] to be used in the short term and only when required (ie, when Mr A became distressed). There is an entry in the rest home nursing notes on 26 June stating that lorazepam should not be given unless Mr A was aggressive.

Ms D states that she asked Dr G to admit Mr A to hospital in order to find out the adjustments to his medication required to address his deteriorating condition. She took three days off work from 1 July 2002 in the belief that Dr G had arranged for her father to be admitted to hospital as requested. Neither Dr G's notes nor the rest home's records mention any discussion about admitting Mr A to hospital.

[3] Pergolide is a medication used to treat Parkinson's disease.

[4] *New Ethicals Compendium*, 7th Edition (Adis International Ltd, 2000) p 1455.

[5] Lorazepam is a benzodiazepine used for anxiety, and insomnia due to anxiety.

*Assessment of mental competence*
On 3 July Dr G carried out an assessment of Mr A's mental competence and recorded that it might be appropriate that the enduring power of attorney come into effect and that it would be discussed with the family and their lawyer. Unaware that this assessment had been undertaken, Ms B also wrote to Dr G on 7 July, requesting that such an assessment be carried out.

On 10 July, Dr G wrote to Mr A's lawyer, advising that she had assessed Mr A's mental competence. She advised that Mr A had scored 17 out of 30 on the MiniMental State Exam, and had problems with orientation, attention and calculation, recall and language. She concluded that he did not have the mental ability to conduct his affairs and that it would be appropriate for the enduring power of attorney to be activated.

Ms H states that the rest home never received a copy of, or sighted, Mr A's enduring power of attorney. She recalls that, in relation to Dr G's assessment of Mr A's mental capacity, "nothing ever came of it". Ms D states that whenever speaking to the rest home staff about a decision relating to Mr A, she (Ms D) would always indicate that before any decision could be made she had to check with Ms C, who held the enduring power of attorney.

Ms B states that her sister, Ms C, had already verbally informed Ms H that she held an enduring power of attorney in late May 2002 and that Mr A's solicitor had also informed Ms H of this fact. She also considers that Ms H should have seen from Dr G's note in the rest home Doctors Notes on 3 July that the power of attorney was activated. However, Dr G's notes did not say that the enduring power of attorney would definitely come into effect; rather, that it might be appropriate and would be discussed with the family. From the information gathered during my investigation I consider that Ms H was aware that Ms C held an enduring power of attorney. While she may not have been aware of the formal steps taken to bring it into effect, she would have observed Mr A's deteriorating mental condition.

*Specialist review*
On 24 July, Mr A was seen by Dr K, who recommended an adjustment of Mr A's medication (stopping selegiline and decreasing the doses of Madopar[6]) and a referral to Dr L with a view to starting an anti-psychotic medication. Dr K also noted family concerns about Mr A's weight loss (his weight was then 59.4kg) and referred him to a dietician to assess whether a dietary supplement was required.

On 6 August, Mr A was reviewed by Dr L. He determined, in consultation with Dr G, that anti-psychotic medication would be inappropriate for Mr A, given the potential side effects of the medication and the fact that his condition had settled. Ms D's view is that Mr A's condition at this point could not be described as settled to any reasonable degree. However,

[6] Selegiline and Madopar are medications used for treating Parkinson's disease.

Ms B suggests that his condition may have settled as a result of the side effects of the pergolide withdrawal subsiding. She also notes that the removal of selegiline improved his mental state significantly, but was only able to observe these changes in mid-September, when she returned from working in Australia.

*Development of sacral wound*

On 9 August, staff at the rest home noted that the sacral area above Mr A's coccyx had started to break down. According to Ms H, the wound was dressed with Allevyn Adhesive as specified in the rest home's wound care policy.[7] It continued to be dressed every second day. Five days later, Dr G visited Mr A at his family's request to review his medication in light of their concerns about side effects and the report from Dr L. She decided that his Parkinson's medication should be reduced. Dr G did not view the pressure wound at that time and from the records it appears that she was unaware of its presence.

Ms B believes that the only time her sister Ms C witnessed a sinus was in late June and that it was not in the area of the wound. However, the rest home stated that the presence of the sinus on 25 May, above Mr A's coccyx, was noticed within the 72- hour period following his admission, and I am satisfied that the sinus was present at that time.

Ms B also states that the rest home did not inform family members at any time of the need to protect Mr A's sacral wound when they took him out for day trips. She also states that the rest home did not discuss treatment options, possible referrals or the need for an air mattress at this time.

On 12 August a Short Term Problems Management Plan was put in place to address Mr A's weight loss. The planned interventions included regular nutritional supplements and weekly weighs, and it was noted that he was shortly to see a dietician. This plan was followed up five days later by a specialised plan of care noting similar interventions and a comment that due to his weight loss he was very susceptible to pressure areas. It is not clear from the information provided whether the weekly weighs were carried out. However, medication records, while somewhat difficult to follow, do show that nutritional supplements were given.

On 15 August, staff observed that Mr A's wound had deteriorated. It was "sloughy", with a necrotic area. This had apparently occurred since it was last dressed on 13 August. The dressing regime was changed to include IntraSite gel, to hydrate the wound and deslough and debride the necrotic tissue. The wound was constantly being compromised by Mr A's faecal leakage. The daily nursing reports from the rest home indicate that manual bowel evacuations were carried out periodically, for example, a manual bowel evacuation was carried out on 20 August with a large result. Ms B's view is that Mr A's faecal leakage could have been remedied by a proper bowel evacuation and she considers that those

[7] Allevyn Adhesive is a foam that promotes granulation and has a sustained uptake of exudates to prevent maceration.

carried out by the rest home staff were inadequate because they did not prevent the wound being contaminated.

Ms B states that family members were not consulted about the decision to debride the wound, and she considers that they should have been. She queries whether the nurses involved had the appropriate expertise to carry out this procedure and whether appropriate pain relief was provided.

Ms H states that on 15 August a "Spenco" was placed on Mr A's bed, which was later replaced with a "ripple" mattress. The rest home provided me with a Short Term Problems Management Plan dated 15 August. This plan noted that the sacral area had broken down and that the situation was exacerbated by nutritional deficiencies. The planned interventions were two-hourly turns, a ripple mattress, occlusive dressings to be changed as required and dietary supplements. There is also an entry on Mr A's Resident Lifestyle Care Plan dated 15 August, which identifies the sacral ulcer as a support need and notes that a "Spenco" will be put on the bed as an intervention. Ms B's view is that because of these two different plans it is unclear which type of mattress was on Mr A's bed at this point and that in any case a pressure-relieving mattress should have been made available as soon as the ulcer was noticed on 9 August. I agree that the notes could have been clearer on this matter, but they are not inconsistent with Ms H's statement that a "Spenco" mattress was used and then a "ripple" mattress.

On 15 August, Mr A, accompanied by Ms D, saw a dietician. The dietician noted the supplements that Mr A was already taking and noted that certain goals had been agreed on, such as encouraging fluids and continuing with the food record and supplements. The rest home also carried out a reassessment of Mr A's fall risk on this date, with his score being increased by one point to reflect his increased cognitive impairment. Ms B considers that preventative action should have been taken at this stage in recognition of the increased risk of falls.

Over the next few days, Mr A became very stiff, and had difficulty mobilising and feeding. He had continual faecal leakage. Ms B confirms that her sister Ms C observed that the rigidity problems became very noticeable at this point and even more so a few days later.

On 18 August a second risk assessment was carried out for pressure sores, using a Braden scale assessment form. Mr A's score was 18, which (according to the rest home's policy) indicates only minimal risk of pressure sores. This score did note an increased risk since the first assessment score of 21 but conflicts with the lower score of 17 noted on the undated Resident Lifestyle Care Plan. This assessment noted that Mr A's nutritional intake was very poor and that he was spending the majority of each day in a bed or chair. No other impairment was noted. Mr A was assessed as having no problems moving, unaided, in his bed. The evaluator's name was not filled in on the assessment form. Ms D disputes this assessment of Mr A's mobility and says that every time she visited her father he needed assistance for most movements required. Ms B also queries the accuracy of the assessment and suggests that Mr A should have been reassessed earlier.

*19 August – fall*

On 19 August, Mr A fell from his chair. He was assessed by a registered nurse and reviewed at regular intervals for concussion. No significant injury was noted. Mr A was not restrained prior to his fall and, according to Ms H, this type of incident had never previously occurred. However, the "falls history" section of the "fall risk assessment" provided by the rest home suggests that Mr A did have a significant risk of falling. His score under the "falls history" section was 12, indicating five or more falls in the six months prior to the assessment. The first assessment that bears this figure was conducted on 28 May, three days after Mr A's admission to the rest home. The rest home nursing notes refer to two falls on 9 and 16 July, with the latter one involving Mr A falling from his chair. Ms B refers to an entry in the nursing notes for 10 June indicating that Mr A was found "cast out" of his bed as also indicating a risk of falls. In her view a restraint should have been considered earlier. Ms D considers that her father was at risk from falling owing to the rigidity caused by his Parkinson's disease, which made it difficult for him to sit upright.

An incident report was completed for the fall. The follow-up actions specified in the report were that Mr A would be positioned where he could be observed by staff at all times. The possibility of a lap restraint was also raised.

On 20 August, Mr A's sacral wound was reviewed and appeared to have improved. Staff also noted that Mr A's left knee was painful. They notified Dr G and requested that she review his condition. The next day, Dr G assessed Mr A for any injuries from the fall and found no evidence of chest injury. There was no complaint of chest pain or difficulty breathing. Dr G treated Mr A for bruising and a cut to the forehead. This was the first time that she noted the presence of a sacral pressure wound, which had recently been dressed by nursing staff. Dr G did not view the wound. She states that staff were reluctant to have the dressings disturbed, as frequently removing dressings is detrimental to the healing process. Dr G inspected the area around the dressing and found it satisfactory. Although the rest home staff were content that the wound was improving, Dr G requested that a blood test and wound swab be taken the next time the dressing was changed.

Ms D states that she asked the rest home staff if Dr G had checked the wound and was told "yes". Had she known that Dr G had not observed the actual wound, she would have requested that she did so.

A wound swab was taken the next day and, according to Ms H, Ms D was informed of the result on 26 August. The nursing notes also indicate that Dr G was contacted with a view to prescribing antibiotics, and that they were commenced on 27 August. There is no record of the results of the wound swab, nor any record of the blood test that Dr G requested, in the information provided by the rest home.

Following Mr A's fall on 19 August, staff introduced a lap restraint to prevent further falls. On 27 August, Ms D signed a physical restraint consent form authorising the use of a lap restraint (Dr G had signed the form on 26 August). Ms B states that the restraint used was ineffective, because the buckle was not secure. Ms D and Ms E confirm this statement. Ms

H disputes this statement and points out that the rest home staff were never aware that the restraint was faulty. She says that the staff can quite categorically state that they ensured that the lap belt was always properly closed, as they were aware of Mr A's high risk of falls.

Ms E recalls taking Mr A for a walk and having to knot the strap. She states that a nurse helped her get him out of the wheelchair and told Ms E that she should not have knotted the strap. Ms E says that she explained the reason it was knotted was because it was faulty and the nurse said that they did not have any others at present. Ms F also recalls this occasion and informed me that on another visit she saw her father sitting in his lounge chair with a restraint that she thought was too tight and wide. Ms B suggests that the fact that none of the rest home staff noticed the faulty buckle indicates that they were not using the restraint. Ms D states that she observed occasions where the restraining belt was not fastened securely.

*Sacral wound deterioration*

During Ms D's visit to the rest home on 26 August, she was informed that Mr A's wound would be treated with antibiotics. Ms H claims that on becoming concerned about Mr A's worsening condition, she contacted Ms D and left a message on Ms C's answerphone voicing her concerns. Ms D does not recall any urgency being expressed in the message left on her mobile phone, perhaps because the situation was not urgent in the sense of requiring an immediate response. According to Ms B, the message left on Ms C's answerphone was about his mobility, not the bedsore.

Dr G reviewed Mr A on 27 August. Her notes record that the wound was not healing and had become "mucky". Dr G observed only the dressings on this occasion. Mr A was started on a course of the antibiotic Ciproxin 500mg once or twice a day, which finished on 4 September. Ms D states that at this stage she was still under the impression that Dr G had reviewed the actual wound. Ms B informed me that her sister Ms C spoke to Dr G on this date or the day after but that the issue of the wound was not mentioned. Apparently Ms C suggested that Mr A should be hospitalised because of his mental state, but Dr G did not consider it was necessary.

According to Ms H, both Ms D and Ms C were explicitly informed of Mr A's condition three days after Dr G's review. Ms D advised me that at no point did Ms H inform her how serious the sacral wound was and the possible consequences if it did not heal. Ms B informs me that according to Ms C, the bedsore was not raised as a serious issue; rather, the focus was on the progression of the Parkinson's disease. The nursing notes for 29 August record that Ms H's discussion with Ms D was about Mr A's deteriorating condition, his decreased mobility and posture, and his decreased appetite. The notes for this date also record that a message was left on Ms C's answerphone asking her to call to discuss Mr A's condition, but details of the following conversation are not recorded.

On 29 August, Mr A was reviewed by a dietician, who suggested an increase in his supplements. The next day, staff at the rest home reported that they were having difficulty keeping Mr A off his sacrum and that he was constantly moving around the bed at night.

However, on the same date Dr G reviewed him at Ms D's request and noted that he was immobile. Ms D also points out that her father had difficulty moving and that the rest home staff had commented that his immobility made him difficult to look after. Ms B states that at this point Ms C observed that her father was suffering from extreme rigidity, his swallowing was extremely poor, and he could not speak. In her opinion he should have been hospitalised at this time.

According to Ms B, it was on 30 August that Ms H told Ms C that a special mattress was being put on Mr A's bed. She infers from this statement that it was the first time that such a mattress was being provided, as opposed to an existing pressure-relieving mattress being replaced.

A support needs assessment for Mr A was carried out on 10 September. As a result of that assessment Mr A was reviewed by Dr J (a consultant geriatrician at the public hospital) on 11 September to ascertain whether he required hospital level care. He was noted to be "comfortable at rest, tremor absent, significantly bradykinetic with prominent rigidity of arms and legs". The next day Mr A was seen by a dietician again. He then weighed 58kg (1.6kg less than on 24 July) and it was noted by the rest home that they were to "persevere" with the existing regime. On 13 September Dr G reviewed Mr A. Nursing staff at the rest home informed her that the wound was improving. As the wound had, once again, been recently dressed, Dr G did not review it.

Six days later, on 19 September, staff noted that the wound had deteriorated significantly. It was frequently being compromised by Mr A's incontinence. Ms B recalls that one day later she was told by one of the nurses that they "were nearly on top of the sore". The wound was dressed with Idoflex, a dressing used in slow healing and infected wounds. Ms H states that Mr A was nursed on a "Lazy-boy" chair with a "Spenco" pressure-relieving cushion. Both Ms E and Ms D state that they do not recall seeing a Spenco cushion on the chair and Ms B says that no other family member saw the cushion either. Ms E says that Mr A was provided with a piece of foam approximately four centimetres thick to sit on.

*Bruising – mid-September*

Ms D informed me that on or about 13 September she visited her father and found that he was uncomfortable and appeared to be holding his ribs in pain. She states that the nurses told her he had fallen out of his chair but had been seen by the doctor and there was no serious damage to his ribs. Ms C saw Mr A the next day and observed that he had a large bruise on his head.

Ms B claims that, on 22 September, she visited her father at the rest home and discovered that "he had a very large resolving bruise on the left side of his head, and a sore right chest". She asked Ms D whether Mr A had been reviewed by a doctor, and Ms D told her he had. I note that there is nothing in the rest home's or Dr G's notes to corroborate this version of events. However, the records show that on 20 and 21 September Mr A's right eye had "moderate exudate" and was cleaned. There is no incident report to suggest a second fall. The version of events supplied by Ms B is, however, consistent with the consequences of

the fall Mr A experienced a month earlier and his subsequent review on 21 August. My provisional view was that Ms B's recollection related to the fall suffered a month earlier.

Ms B disagreed with this view since she was working overseas from 28 July to 16 September 2002 and therefore could not have seen him after his fall in August. She states that she did, however, witness his injuries on 22 September when she had returned. She has also provided a photograph of her father apparently taken on 20 September showing a bruise on his head, and indicated that other family members had also seen the bruise. Ms B states that her father was also complaining of a sore right chest and it was still sore on 27 September when he visited the family farm on his birthday. She has provided me with a copy of a photograph taken on this date in which Mr A is sitting on a foam squab that the rest home had provided to the family.

Ms B describes the bruise on Mr A's head as very large and yellowing. She initially suggested that a reference in the nursing notes to a skin tear on 11 September or a later reference on 17 September stating that Mr A had to be seated in a geriatric chair, and not the Lazy-boy, could indicate that he had fallen and that it was not recorded because the restraint had not been used when it should have been. Later, having checked her phone records, Ms B informed me that on the night of 13 September one of her sisters told her over the phone that Mr A had had a fall. She indicates that the family was informed only when they visited him and were also told he had been reviewed by a doctor. Dr G informed me that she did review Mr A on 13 September but did not mention a fall or any resulting injuries or record them in her notes. She notes that she was informed that the sacral wound was improving but did not view it as it had been dressed. Ms B suggested that Dr G may only have reviewed Mr A's notes; however, Dr G has confirmed that she did review Mr A in person.

Ms F informed me that in September she saw a large bruise on the left side of his head. When she asked about the bruise she was given two different explanations – that he had fallen over the footstool in his room and that he had fallen forward while seated in his wheelchair in the dining room and hit his head on the table. Ms D states that she visited Mr A around this time and observed severe bruising and a cut to his head. He also had severe pain in his chest, which made it difficult for him to breathe or talk. When she asked the staff how the injuries had occurred she was told that he had fallen out of his armchair. Ms D requested that he be secured in any chair that he sat in and noted that she had not been contacted about the fall.

*Review of sacral wound by Dr G*

On 4 October, Dr G reviewed Mr A at the request of Ms D, who was concerned about his mental state. In Ms B's view, Mr A's increasing confusion was secondary to sepsis from the sacral wound. This was the first time that Dr G actually viewed the wound under the dressing. Her notes reveal that it was "smelly and nasty" and about 6cm in diameter. Upon viewing the wound, Dr G decided to commence Mr A on a further week's course of antibiotics. Dr G recalled that Mr A was being nursed from side to side in bed or on a Lazy-boy for short times. She also states that he had a special alternating air mattress that

was used specifically for pressure sores. According to Dr G, surgical intervention was considered but eventually disregarded on the basis that Mr A was not a suitable candidate for surgery.

Ms B states that none of the family were consulted about the decision against surgical intervention. She considers that a surgeon and anaesthetist should have been consulted. Ms B also considers that Dr G's suggestion in the notes that "any available padding and protection should be used" indicated that current practices were inadequate.

Ms H states that on 4 October Mr A was provided with an Apollo pressure-relieving mattress, because the "ripple" mattress was not providing sufficient protection, and staff were advised to keep him off his sacrum whenever possible. Ms H provided me with a brochure about the Apollo mattress used; it indicates that they are suitable for "patients having pressure sores classified as stage 1 or 2 sores". Entries on Mr A's Resident Lifestyle Care Plan and the Short Term Problems Management Plan relating to the sacral wound dated 1 October suggest that the Apollo mattress was to have been placed on the bed at that time. The entry in the Resident Lifestyle Care Plan also notes that Mr A was to be kept off his sacrum and turned every two hours.

Mr A's incontinence continued to complicate the management of his sacral wound and by this stage his dressings were being changed two or three times a day because of the constant faecal leakage. A urodome was put on Mr A to try to protect his dressing from being compromised with urine. The rest home staff continued to dress the wound with IntraSite gel and Allevyn Adhesive and also used OpSite and Rozex gel.[8] Ms H states that the rest home attempted to obtain an assessment from a wound care nurse about this time, but the specialist nurse was away on leave. No record of any such request, or of any attempts to make alternative arrangements, appears in the records provided by the rest home.

Ms B has noted that temazepam and lorazepam were also listed on the medication sheet for 4 October and queries why sedatives were prescribed. In her view sedatives increased other risk factors such as aspiration, and reduced mobility, food intake and the ability to communicate. Having checked Dr G's notes for this date, I cannot see any reference to these medications and why they were prescribed. They are noted on the medication sheet but there is no corresponding administration record.

On 14 October, Dr G saw Mr A again and reviewed his dressings. She noted that the wound was extending, and looking and smelling offensive. Despite the use of antibiotics, Mr A was deteriorating in general. Dr G states that she left a message for Mr A's family to contact her if they had any concerns. Ms D states that in no conversation did Dr G make her aware of the extent of her father's deterioration. Ms B also queries who the message was left with.

[8] Rozex is an antibacterial/antiprotozoal.

Ms H informed me that aperients (laxatives) were discontinued the next day and that Mr A was started on Isogel instead. She stated that the faecal leakage discontinued and staff had to carry out manual bowel removals. The nursing notes indicate that while there were small amounts of faecal leakage, it did not compromise the dressing of the sacral wound. Isogel is in fact a laxative. Also, there is no mention in the records of it being administered. The medication administration records do show that Mr A was given Coloxyl and senna (laxatives) up until 19 October and Conthram (also a laxative) up until 27 October.

*Information provided on 17 October*
Approximately four days later, the rest home staff irrigated the wound area with warm sodium chloride and debrided a significant amount of necrotic tissue from Mr A's wound and then dressed it with IntraSite gel and Flagyl gel (an antibacterial product). Ms H claims that she explained the debridement process and the size of the wound to Ms D and that she repeated her explanation to Ms C the following day. She also told Ms C that "there was an improvement in the wound". Ms C accepts that this conversation occurred, but disputes the date. She states that when she talked to Ms H, on or around 17 October, she was told that the wound was improving. Ms B also states that this conversation did not make Ms C aware of the severity of the wound.

Ms H states that she told Ms C that they had debrided a lot of tissue and that there was granulating tissue present, which was good. She also explained the size of the wound, using the palm of her hand, and its depth. She told Ms C that there had been some improvement but that it would be a long, slow process. Ms H states that Ms C then reinforced this statement to her father, saying it was going to be slow "like the tortoise and the hare" but that they would get there. Ms B indicated that Ms H spoke to her rather than Ms C on this occasion and that the conversation was no longer than 15 seconds. She also states that when she saw her father he was sitting in a Lazy-boy chair with no padding or restraint, and on a drip looking dehydrated. Ms C said that she was the one who made the tortoise and hare comparison and it was in relation to her father's medication, not the sacral wound.

Ms D also recalls being told that the wound was improving. She states that Ms H suggested that Mr A should be taken for a walk in the sunshine but the chair provided was broken and had no supporting cushion on the seat. Ms H asked that the family were discouraged from taking Mr A for walks but requested to do so. Ms H informed me that these requests were discussed with Dr G and it was agreed that Mr A could go for walks in the Lazy-boy chair with a Spenco cushion and would be put straight back to bed afterwards. A factor in this decision was apparently that Mr A was increasingly depressed.

Ms E told me that she would take her grandfather for walks in the wheelchair as he did not like lying down all day. She says that she checked with Ms H that it would not compromise the sacral wound and was told that it would not. Ms E says that if she had realised how bad the wound was she would not have had him sitting on it in the wheelchair.

On 20 October Ms B visited Mr A. She states that he was not restrained at all and that he had not been provided with a pressure-relieving mattress or Spenco cushion at that time.

Instead he had a foam squab to sit on and the "dishevelled" sheets revealed an ordinary hospital mattress. She also informed me that when Ms C visited her father on 17 October, he had been placed on his sacrum in bed with no protection, and that this occurred again on 19 and 20 October. Ms B also states that when Ms C visited their father on 24 October she partially remade his bed and there was only an ordinary mattress.

*21 October – consultation with Dr G*

On 21 October, Ms C consulted Dr G at her surgery. Ms C claims that the main purpose of this meeting was to discuss her father's health. Dr G understood that the consultation was primarily to discuss Ms C's health. They first discussed some matters regarding Ms C's health and then discussed Mr A. At the time, Dr G was aware of Ms C's enduring power of attorney in relation to her father. Dr G states that she told Ms C about Mr A's deteriorating health, and asked her how aggressively she wanted him to be treated. Ms C states that Dr G did not tell her how serious the wound was and did not explain the treatment she had provided. According to Ms B, her sister Ms C acknowledges that Dr G did indicate that Mr A's health was declining. Dr G states that she explained Mr A's condition to Ms C, including his worsening wound and general decline. Dr G's contemporaneous clinical notes read:

"Long Disc. re dad.
- General poor condition
- Parkinsons
- Pressure area
- at risk something like pneumonia"

Dr G's clinical notes also include the statement that "[Ms C] wants all measures taken".

Ms D states that when she discussed the consultation with Ms C, the bedsore was not mentioned and Ms C said that she had told Dr G that she had to discuss the situation with Ms D before making any decision.

As the consultation was with Ms C, and had dealt first with her health, Dr G recorded this consultation in Ms C's notes, not Mr A's.

Shortly thereafter, Dr G discussed Mr A's care with a consultant geriatrician, Dr J, who suggested contacting a specialist wound care nurse. Dr G attempted to do so, but the nurse was still on leave. Ms B considers that Dr G should have contacted the wound nurse earlier and suggests that the only reason it was done at all was because of Ms C's visit. She also considers that surgical advice should have been sought.

*Acute admission*

At approximately midday on 27 October, Mr A became acutely unwell. Ms H states that Ms D was informed and a doctor was called to attend that afternoon. Ms D states that she was not told that it was urgent and that she should come to the rest home immediately. According to Ms B, when family members reached the rest home, Mr A was in severe

distress. He was conscious, but breathless and blue in colour. Ms E and Ms D state that the rest home staff had not given Mr A oxygen and were not doing anything to assist him. Ms H states that, as a significant amount of fluid was coming from Mr A's mouth and nose, they thought it was inappropriate to use an oxygen mask, which would fill up with the fluid.

Ms D's recollection is that there were saliva bubbles in his mouth but not an excessive amount. Ms E told me that although there was fluid in Mr A's mouth it did not appear to cause any problems when an oxygen mask was used by the ambulance driver. In Ms B's opinion, suction should have been used if available, as should an oxygen mask, which could have been emptied if it filled up with fluid. She considers that it is unacceptable not to have provided oxygen to Mr A when he was in respiratory distress. Ms H stated that from the point when he became unwell there was a rest home staff member with Mr A at all times; however, Ms B indicates that Ms E was left alone with him for some time.

Because of Mr A's distress, his family requested that staff call an ambulance. In response, the nurse on duty rang the doctor's surgery to enquire where the doctor was. She was told that the doctor had been delayed owing to car problems. The duty nurse then asked the surgery to call an ambulance. Both Ms D and Ms E indicate that it was only at Ms E's insistence that the staff requested an ambulance. Ms B considers that the ambulance should either have been called much earlier or the doctor should have been informed that the situation was urgent. She is also critical of the rest home staff for not calling the ambulance themselves, as the first ambulance sent was a transfer ambulance and was not equipped to deal with the situation, so a second ambulance had to be dispatched.

When the ambulance arrived just before 2pm, Mr A was given oxygen. Ms B notes that no mention of fluid is made in the ambulance report and that Mr A's lips were noted as being dry. She disagrees that the ambulance officer had to stop giving oxygen because of the fluid, and points out that according to the report, maximum oxygen therapy was given and there was an improvement in oxygen saturations. Ms D and Ms E recall that the ambulance driver apologised to them for taking control and acting abruptly with the rest home staff, commenting that they did not seem to know what they were doing and he felt there was some resistance to his actions.

Mr A was admitted to the public hospital at 2.29pm in respiratory distress. A chest X-ray showed a possible infection in Mr A's right lung and fractures in the lower right rib cage.

*Subsequent events*

On 2 November Mr A was reviewed by a general surgeon, who was of the opinion that surgery would be "unkind and futile". Two days later, Mr A was assessed by a wound care specialist, who considered that the sacral wound would have been unlikely to heal with wound management. Further, she did not consider that Mr A was a candidate for surgery. According to Ms B, the wound care specialist spoke to Ms C on 3 November and did not indicate that there was no remedial treatment; instead she discussed use of a vacuum pump and nutritional supplements. She also indicates that Mr A's ability to communicate actually

improved in hospital, which she considers is because sedatives were withdrawn, the sepsis was treated, and he had regular food and pain relief as well as a pressure mattress.

Mr A died shortly after. Mr A's death certificate recorded the direct cause of death as being "Sepsis" of five days' duration. It also noted antecedent causes, which led to the sepsis, as "Pneumonia – aspiration", approximately 15 days' duration; "sacral pressure ulcer", approximately two to three months' duration; "Parkinson's disease, likely causing aspiration", seven years' duration.

On 21 November Ms C wrote to the general surgeon under whom Mr A was admitted to the public hospital, asking for clarification about the sacral wound. The general surgeon responded to Ms C's letter on 2 December. He stated:

> "The usual cause of such wounds is pressure for longer than the skin can survive without a blood supply. It is a common problem in very sick people such as [Mr A] who make very little spontaneous movement, sitting or being in any one position for more than about four to six hours is likely to produce such an ulcer at the point of pressure on the bed or chair. In someone like [Mr A], who was in the last stages of Parkinson's disease, unremitting nursing care day and night with frequent movement, preferably two hourly, is necessary to prevent such a pressure area developing … The outcome of the ulceration would not have been in any way made different by early detection, the ulcer that I could see was inevitable, given that sufficient period of pressure had occurred sometime in the past. Had he survived, it might have been possible to heal this by conservative means in six months to a year."

*Broken ribs and suspected falls*

Ms B and Ms D state that neither Dr G, nor the rest home, ever informed them that Mr A had broken ribs. They also believe that Mr A had a fall in mid-September that was not documented by the rest home, and which they were only informed of when they visited and saw the resulting bruising.

Ms D states that the family believes that Mr A suffered a second fall in September, which "almost certainly" led to the fractured ribs, which in turn predisposed Mr A to pneumonia. Ms E informed me that after Mr A had fallen she specifically asked a nurse whether his sore chest could be a broken rib, and was assured that the doctor had checked it and the injuries were superficial. It is not clear from her letter whether Ms E is referring to the fall of 19 August or the fall suspected to have occurred in September. Ms F states that the rest home staff told her that Mr A had fallen over a footstool and also that he had fallen forward hitting his head on the dining room table. She also informed me that on one visit her father mentioned that he was sore on his right side but that she thought it was because of the way he was sitting.

Ms H, on behalf of the rest home, advised me that they were surprised to hear that Mr A had broken ribs, and were unable to explain how that could have happened. She noted that if Mr A had fallen at any time, staff would have known as he would not have been able to

get up on his own. There is no mention of Mr A suffering a fall in September in any of the notes and records provided by Dr G or the rest home, nor is there any incident report for a fall during September.

Ms H commented that when someone is as frail as Mr A was, it is possible to fracture a rib through coughing. Dr G also stated that Mr A could have broken his ribs from coughing due to his pneumonia. Ms B considers the suggestions from the rest home and Dr G that he broke his ribs coughing to be implausible for the following reasons:

1. Mr A had a mobility disorder and had previous falls;
2. he did not have a forceful cough due to his Parkinson's disease;
3. the fractures were unilateral and multiple;
4. the fractures were very low and very lateral;
5. she could see no evidence of osteoporosis in his chest X-ray;
6. in her clinical experience of patients with severe respiratory distress she had never seen any break multiple ribs on one side of their body; and
7. she discussed her father's injuries with a forensic pathologist who said that he had not seen a single case of multiple unilateral rib fractures from coughing.

Ms B requested that Dr M, a consultant radiologist, review the X-ray of Mr A taken at the public hospital on 27 October 2002. In a letter of 16 September 2004 to Ms B, Dr M states that there was no significant callus formation, which suggested the fractures were of recent origin at the time of the X-ray. Dr M also states that there is no definite evidence of an underlying bone disorder and that "etiology is not easy but trauma would seem more likely than coughing as a mechanism for these fractures". The X-ray report from the public hospital on the day Mr A was admitted does not make any mention of the age or cause of the rib fractures.

Apparently when Ms B discussed the report with Dr M she said that the fractures had probably occurred one to two weeks prior to Mr A's admission to hospital. In a further report dated 3 May 2005, Dr M confirms her view that the fractures to the 7$^{th}$ and 8$^{th}$ ribs appeared "less than approximately two weeks old" while the fracture of the 9$^{th}$ rib was "slightly older but no greater than two or three months old". She was unable to give an approximate date for the fracture of the 10$^{th}$ rib.

On the basis of this information Ms B suggests that the older fractures may be attributable to the fall that the family consider occurred in mid-September. Based on Dr M's second X-ray report she considers that her father suffered a further traumatic injury in October 2002 which was also not documented. She suggests that the fact that the rest home staff listened to Mr A's chest on 25 and 26 October could mean that they were aware of a chest injury. The notes for these dates also record that Mr A was coughing, which would have been a reason to listen to his chest. Ms B also suggests that the injuries to Mr A's ribs were deliberately concealed as they were sustained after the restraint order was signed, and that if all appropriate measures had been taken by the rest home these injuries would not have occurred. In her view the fractures must have significantly contributed to his death from

pneumonia, and she refers to his hospital notes where the doctor admitting him noted an impression of pneumonia secondary to fractured ribs.

Ms C's opinion is that the most recent fractures had not occurred when she saw her father on 17 October. Her view is that, based on her father's conduct and what she considered to be the unusual behaviour of the rest home staff, the most recent fractures occurred on 22 October.

Ms B is very concerned that her father suffered two sets of injuries and neither of them was recorded. She considers that at least one the rest home staff member must have witnessed what happened to cause these injuries and notes that he was not independently mobile and more than one person would have been required to lift him if a fall occurred. In her view the fact that the injuries were not recorded is suspicious, as is the failure to inform the family of the broken ribs.

I accept that in mid-September the family observed bruising on Mr A's head. How the bruise was sustained is unclear. According to the family at least two family members (Ms F and Ms D) were informed that the bruise was caused by Mr A falling from his chair. However, there is nothing in the notes provided by the rest home or Dr G recording the fall or detailing any injuries. Ms B suggests that Dr G may not have examined Mr A in person on 13 September and that this is the reason she did not record any injuries. Dr G has confirmed that she did review Mr A in person on 13 September but could not recall whether any bruising was present. It is also possible that the injuries may have occurred after Dr G's visit. Ms H, on behalf of the rest home, also informed me that Mr A had no falls subsequent to the one on 19 August. I accept the family's account of seeing bruising in mid-September. While a fall would appear to be a likely cause of the bruising, on the basis of the conflicting information that I have obtained I cannot form a definite conclusion as to the mechanism of injury.

Likewise, the timing and cause of Mr A's fractured ribs is unclear. Information obtained by Ms B suggests that some of the fractures occurred in October while others occurred two to three months earlier – ie, between late July and late August. The report from Dr M notes that it is not easy to determine the cause of the fractures but suggests trauma is more likely than coughing. As for when such trauma occurred, Ms B considers that it was most likely to have occurred some time in October and mid-September. Other family members report Mr A having a sore chest in September. There is even a note of pain at the bottom of Mr A's ribs as early as 14 June and on 16 July the rest home notes record that he tumbled from his chair and bruised his lower rib cage. Ms C's view is that the most recent fractures occurred on 22 October. While Dr M's second X-ray report is more specific about the age of the fractures, I remain of the view that it is not possible to identify with certainty the timing and cause of the fractures to Mr A's ribs. Ms B considers that the timing and cause is not as relevant as the fact that fractures did occur, were not documented, and were preventable and untreated, and I address these matters below.

*Pneumonia*
There is no record of Mr A being diagnosed with pneumonia prior to his admission to the public hospital. The first reference to any possible problem is on the rest home's nursing notes from the night of 25 October, which record "coughing at times", then on the afternoon of 26 October, "chest sounding clear". At their meeting on 21 October, Dr G explained to Ms C that, because of his general condition, Mr A was at risk of pneumonia.

*Use of pressure-relieving devices*
The family have complained that the rest home did not provide Mr A with pressure-relieving devices. I have received the following statements from members of the family about the presence of pressure-relieving devices:

- Ms B has stated that there was no pressure-relieving mattress on Mr A's chair when she visited on 19 October or on his bed when she visited on 22 September, 27 September or 20 October and reiterates that no one in the family ever saw a ripple mattress on the bed or any air pump or pipes. She also states that the ripple mattresses she had seen in hospital were "noisy".
- Ms E told me that in hospital an air mattress was provided but that she had never seen this sort of mattress at the rest home.
- Ms F states that when she took her father for a walk she was not given a Spenco cushion. She also informed me that she never saw an air mattress on his bed and that she was familiar with what such mattresses look like, having worked as a care giver.
- Ms D informed me that she does not recall seeing any mattress on Mr A's bed other than the one that he had when he was admitted to the rest home.
- Ms C states that she never saw a Spenco or air mattress from 25 May to 7 September, on 17 October or from 22 to 24 October. According to Ms C, the mattress she saw on the bed on 24 October was a blue colour, whereas an Apollo mattress would have been light brown (the Apollo mattress brochure provided by the rest home shows a light brown mattress).
- Ms B has also informed me that there was no padding on the lounge chair that her father sat on, only a plastic incontinence cloth.

During my investigation the rest home provided me with information about the chairs, mattresses and other pressure-relieving devices used to care for Mr A. These included a number of different mattresses and a Lazy-boy chair. I also note that the use of the ripple mattress and the change to an Apollo mattress is documented in the Management Plan, as is the use of a "Spenco" cushion on the Lazy-boy chair.

Dr G also stated that when she saw Mr A on 4 October, a pressure-relieving mattress was being used. She refers to an "alternating air ripple mattress"; the rest home Care Plan and Short Term Problems Management Plan refer to an Apollo mattress being used from 1 October onwards; Ms H stated that the ripple mattress was replaced by an Apollo one on 4 October.

Ms B informed me that after her father had left the rest home, members of the family saw a mattress and bedding specialist working in the hospital wing at the rest home. She suggests that this is where Ms H obtained the information about pressure-relieving devices. Ms B has spoken to a company that supplies air mattresses and they informed her that Ripple or Apollo mattresses are only appropriate "where no bedsore exists yet and the risk factors are low". She also contacted the companies mentioned in the brochures provided by the rest home and says that they have no record or recollection of renting such mattresses to the rest home.

Ms B provided me with photographs of Mr A's bed and wheelchair, which she considers demonstrate that the rest home did not take the measures that they have described. There are two photos of the wheelchair. Ms B informs me that the first photograph was taken in late July and the second between 20 and 26 September. In the first photograph only a small part of the wheelchair seat is visible and it is not possible to ascertain whether there was any padding on the seat. The second photograph shows a white quilted covering on the seat of the wheelchair, which Ms B informs me is a standard incontinence sheet with no padding. The photographs of the bed taken on 20 September do not clearly show the type of mattress on the bed, although the small part that is visible is light brown. Ms B states that the mattress shown is a standard hospital one with no pressure-relieving qualities. She has also provided photographs of beds with an air mattresses and Spenco to illustrate the differences. In her view, even if a pressure-relieving mattress would not have changed the outcome in relation to the sacral wound, it would have made her father more comfortable.

In summary, there is a conflict between the information provided by the rest home and Dr G and the family's account of the pressure-relieving devices used. The rest home has provided contemporaneous but not entirely consistent records which refer to the use of pressure-relieving mattresses and cushions. However, five members of the family have provided me with information and they all state that neither they nor any other family members ever saw a pressure-relieving mattress on Mr A's bed, and that little or no padding was placed on chairs.

I have no reason to doubt the sincerity of the statements made by members of the family, which clearly represent their recollection of events, and indeed had no doubts on this point before they provided sworn statements. However, I am faced with a conflict in the information. My provisional view was that the contemporaneous records were likely to be more accurate than personal recollections months or years after the events in question. However, the information provided by the family in response to my second provisional opinion has highlighted further doubts and uncertainties as to the pressure-relieving devices used by the rest home. In my view it is not possible to reconcile this evidential conflict.

*Medication*
The family have complained that the rest home did not appropriately manage Mr A's medications. Mr A was on a number of medications throughout his stay at the rest home. They included medication to control his Parkinson's disease, sedatives, laxatives, antibiotics and analgesics. Ms B raised a number of concerns about the management of the medication that Mr A was receiving for his Parkinson's disease. However, these concerns relate to the services provided by doctors who are not subject to this complaint, and Dr G. As stated earlier, I have decided to take no further action on this complaint insofar as it relates to Dr G. Therefore it is only the appropriateness of the rest home's management and administration of Mr A's medication that is under consideration. I recognise that it is the doctor's responsibility to prescribe appropriate mediations.

Dr G had prescribed lorazepam to be administered by the rest home staff "prn nocte" – ie, nightly as required. There was already a standing order from Mr A's previous GP for temazepam nightly as required. Ms B informs me that Mr A was sedated without the knowledge or approval of his family. She indicates that when Ms C became aware of this sedation she requested that it be discontinued unless he was a significant risk to himself. Ms B considers that sedation increased the risk of falls, made communication difficult and increased his risk of pressure ulcers and poor food intake. She points out that lorazepam, which has sedative effects, had been given to her father on 9 and 16 July and he later had a fall. Ms B is also concerned that Kapanol (morphine sulphate) was discontinued after only two doses on 15 and 16 October.

When Dr K reviewed Mr A on 24 July 2002, he noted that Mr A had been taking temazepam or lorazepam as necessary. He could not tell from the records provided to him at the time how often this had been used.

I have had considerable difficulty in interpreting the information provided by the rest home about Mr A's medication. This information includes "Medication Administration Records", "Non-Packaged or PRN Administration Records", "Medication Sheets" and notes made in the "Doctor's Progress Notes" and "Daily Nursing Reports". Because of the large amount of information provided, the significant period of time that it covers and the apparent inconsistencies and gaps in the records, I have not attempted to summarise all of the management of Mr A's medication. I note that my expert nursing advisor has made a number of comments on the management and administration of Mr A's medications in her advice below.

*Case review by wound care nurse*
On 12 November the IV and Wound Care Coordinator at the DHB carried out a case review of Mr A's care. The relevant sections of her report are set out below:

"Identified risks:
- History of weight loss, requiring dietary assessment and input. Weight had dropped from 68kg in 1999 to 58.8kg in August 2002 …
- Significant reduced level of mobility from Parkinson's.

- This is further complicated by paranoia and other psychiatric problems as pt reported to dietician that he did not trust the food at the rest home and that they were trying to poison him. Was referred to Dr L.

**Admission:**
Admitted to […] under Dr J 27th October 2002 with sepsis.

Admission signs and symptoms:

Pneumonia and aspiration secondary to Parkinson's
Dyspnoea
Chronic active hepatitis
Pressure areas (Waterlow scale 27)
Albumin was low (28) consistent with malnutrition
Hb was 106
Temp 37.3
Hypoxia PO2 86.5

Treated on admission (IV Cefuroxime and oxygen)
Surgical review of pressure ulcers by […] 2/11/02. 'documented as result of long term pressure', … Escher debrided down to bone …

Sacrum: Photographed 31/10/02:
Stage 4 ulcer, wound base 50% eschar and 50% granulation on sacrum, peri-wound area dusky pink, probably non-blanching erythema. Malodorous, and heavily exudating. Shape of ulcer consistent with direct pressure rather than shearing forces.

Left hip: stage 2 ulcer small wound with sloughy base.
Ankle: Stage 2 ulcer on ankle, clean wound base.
Wound review by […] 4/11/02 Waterlow scale assessed at 27 (28)
Issues:

- Pt was at high risk for pressure areas, there was no risk assessment documented in records sent to hospital.
- May not have been taking his supplements? This would be consistent with pts confusion and paranoia regarding food (Low albumin indicates a nutritional deficit of about three months as serum albumin has a long half life.)
- Parkinson's was contributing to lack of mobility in bed or chair and difficulty in turning over in bed was documented as early as 1997.
- Wound charts sent in with patient clearly documented wound stages, exudates, and dressing choice. I noted that the hip wound wrongly staged as a 4 when it was probably only a 1 or 2.
- Perhaps family expectations were not identified prior to admission regarding his risk level, treatment outcomes and prognosis. At a meeting in the ward they were given a clear expectation by [Dr J] that treatment would not change the outcome. Some members had trouble coming to terms with this. Family discussion continued right up till patient's death around decisions to treat or palliative care.

- Appropriate dressings were being used at the rest home and provided optimal wound bed environments (Allevyn and Hydrogels)
- It is unlikely the sacral ulcer would have healed with wound management alone due to pts general condition. Earlier surgical debridment may have reduced infection risks, however the decision needed to be made after consideration of [Mr A's] family wishes on palliative vs active treatment. He was clearly not a candidate for reconstructive surgery."

In her response to my first provisional opinion, Ms B stated that the comment in the report about continuing discussions about palliative care was a misinterpretation of a conversation of which the wound care nurse had overheard only part. She also states that Mr A was not paranoid for two months, therefore this was not the reason he had not been given nutritional supplements. Ms B suggests that the IV and Wound Care Coordinator's report indicates that she did not have access to full records from the rest home or the hospital. She also states that the report appears to discuss only the late management of the wound and not preventative care.

*Ministry of Health audit*
Ms B provided me with a copy of an audit report from the Ministry of Health for the rest home dated 30 April 2002. She notes that the rest home was only partially compliant in the medication area owing to findings that the registered nurse had been prescribing medication, telephone orders were not always signed by the responsible doctor, and medication reviews were not traceable, although it was noted that a review system was being implemented. The rest home was fully compliant in the assessment and management of pressure area risk, although it was noted that education had not occurred recently and was planned for January 2003.

Ms B considers that the rest home should have been on notice that these issues required immediate attention and that the report supports her view that the care provided to her father in these areas was below the appropriate standard and in particular that an earlier referral to a wound management nurse was warranted. I have not gathered information on any further audit activity undertaken by the Ministry of Health. The Ministry of Health has confirmed that the rest home is currently certified under the Health and Disability Services (Safety) Act 2001 and was licensed throughout the time when Mr A was at the rest home.

## Responses to First Provisional Opinion

*The rest home*
In response to my first provisional opinion Ms N, Director of Aged Care Services at the rest home, advised me that since the complaint, a number of steps had been taken by the rest home to improve services. Additional support and resources are now available for managers, including "regular visits, additional senior staff being appointed as Care

Managers and a review of all documentation resulting in the introduction of generic documents" in all of the facilities. She also stated that education and training are being provided for all staff.

Ms N said that she was very concerned about the issues around medication and spent two days at the rest home ensuring that the staff were all familiar with the new policies and procedures. All staff who administer medications must now have completed Drug Administration Competency. The documentation used in this area has apparently already been found to be compliant with the Health and Disability Sector Standards (Certification) Audit requirements.

The new documentation introduced included a pain management policy and a pain assessment form. Staff involved in wound care are now required to complete "an annual competency". Ms N stated that because of the changes already made, she felt confident that the rest home has addressed the issues raised in my first provisional opinion.

In response to my provisional view that the rest home had breached the Code in relation to the treatment of Mr A's sacral wound, Ms N conceded that action from staff should have occurred earlier with regard to informing Dr G of the deterioration of the wound. However, she feels that it is "somewhat harsh" to conclude that this omission was a breach of the Code.

Ms N advised that she believed "that more appropriate and empathetic communications could have occurred and this would have made a significant difference to the eventual outcome of this case". She believed that the risk of a similar incident occurring has been significantly reduced.

Ms N included a letter of apology to the family for the rest home's breaches of the Code.

I was advised by Ms N that Ms H has resigned her position and is no longer employed by the rest home.

*Mr A's family*

In response to the "information gathered" section of my first provisional opinion, I received responses from Ms B, Ms D and Ms E. Where these responses disputed facts set out in the "information gathered" section of my opinion, I have included the response there. Those responses that raised other matters or were of a more general nature are set out below.

*Ms D*

In response to my first provisional opinion, Ms D made the following comments.

Ms D considers that the admission procedure did not include putting an adequate plan in place for providing members of the family with information. She obtained most of her information when she visited her father and also called Ms H on a number of occasions. It is her recollection that Ms H would have called her only two to three times.

Ms D considers that it was Ms H's responsibility to speak to Dr G on a regular basis about Mr A. She also considers that Dr G should have told Ms H that the enduring power of attorney had been activated.

Ms D queries whether it was appropriate for Ms H to carry out the debridement of the necrotic tissue and whether she had the skills to do so. It is also her view that Dr G should have looked at the sacral wound much sooner. When the wound care nurse was unavailable, Ms B considers that Dr G and Dr J should have found someone else to see her father.

Ms D states that throughout the last three months of her father's life she was never led to believe that it would be his sacral wound that would cause his death. She says that the hospital staff said it was the worst such wound that they had seen in 17 years.

*Ms E*
In response to my provisional opinion, Ms E made the following comments:

Ms E considers that the rest home staff blamed Mr A's deterioration on Parkinson's disease and did not inform her or any other family member how serious the sacral wound was becoming. It only became apparent to the family when he was admitted to hospital, and this was devastating. She also considers that when the wound nurse was unavailable, more should have been done to find another wound care specialist to see her grandfather.

She indicates that at one stage he was on a drip and when she queried the reason, Ms H told her it was because he was having trouble swallowing. However, Ms E wonders whether it was because of the wound. Ms E recalls speaking to Ms H around the time that the wound was debrided for the first time. She remembers being told that the surface of the wound had been scraped to promote healing, that not much had to be scraped off, and that a new ointment would heal the sore. She had no idea that the process involved cutting flesh away.

Ms E recalls that when Mr A was admitted to hospital the nurses were horrified at the state of his nutrition and bedsore. She states that "it was a shocking experience at the hospital to realise he had not been given an acceptable level of care but that now there was not time to remedy it and his death was likely to be inevitable".

*Ms B*
Ms B said that her impression of my first provisional opinion was that it suggested that her family could not come to terms with the fact that her father had end stage Parkinson's disease. In her response she stated very clearly that the family were aware of his prognosis and expected him to die of Parkinson's disease but did not expect that preventable injuries such as falls and pressure wounds would contribute to his decline.

Ms B provided me with an internet reference for information about bedsores, which suggests that they are a sign of neglect. Her sister, Ms F, told her that the rest home policy book also stated that bedsores were a sign of neglect, and she suggests that this is the

reason why full disclosure was not made to the family. Ms B's opinion is that her father should have been referred to a wound care specialist or surgeon much earlier.

Ms B considers that the rest home did not take adequate measures to prevent the wound occurring, especially as her father was noted as being at high risk of pressure sores. She considers that an air mattress should have been provided from the outset and included a copy of information from the internet that states that such beds have been shown to reduce the development of pressure ulcers. She also queries whether the rest home's wound care policy took into account the need to prevent pressure on pressure sores. Ms B states that numerous family members visited Mr A but no one ever saw the staff alter his position or stand him up to relieve pressure. Ms B also suggests that the sacral wound was not adequately dressed.

Ms B considers that the rest home's references to mattresses are incongruous and it is not clear whether they were a plan or an action. She thinks it is important that there is no mention of a mattress in the daily nursing notes or in Dr G's notes, despite it being a critical intervention.

Ms B suggests that Dr G should have looked at the actual wound the first time she saw it, rather than leaving the dressings on. She is also concerned that the family were not advised to use pressure-relieving devices when taking Mr A out for day trips.

In Ms B's opinion, the letter from […] was an attempt to comfort Ms C by saying that the progression of the wound was inevitable. However, it is Ms B's view that such a wound should not have happened and should not be regarded as inevitable. She informed me that in the four years that she worked in intensive care, she had never seen any bedsore left to progress to anywhere near the level of her father's. She would not have believed anyone would allow a wound like this to develop and considers that those involved in Mr A's care had weeks in which to seek the appropriate advice.

Ms B advised me that when Mr A was hospitalised, the nurse manager for his ward told her that she was going to visit the rest home and speak to the manager to provide advice and information about bedsores to prevent other residents having the same thing happen to them. When she met with the nurse manager on 4 November 2002, Ms B says she was told that the rest home "hadn't even had him on a mattress or put the right creams on". At a later meeting on 20 November 2002 the nurse manager was apparently shocked when Ms B told her that the family had been encouraged to take Mr A out for walks in a wheelchair with little protection.

Ms B informed me that she was about to qualify as an intensive care and anaesthetic consultant and that she has worked as a medical practitioner for 14 years. As a medical practitioner she considers the suggestion that her father broke four ribs from coughing to be totally implausible. She points out that in the rest home nursing reports for 16 July 2002 there is a partially documented injury to Mr A's ribs.

It is Ms B's view that the inevitability of her father's death was used as an excuse for poor care and wilful neglect. This misses the point whether he received adequate care of a standard appropriate for a hospital-level facility.

Ms B is very concerned that the family still have no idea of the cause of Mr A's fractures and head injuries and whether they were accidental or malicious. Her view is that these injuries contributed to Mr A's pneumonia and subsequent premature death. She believes that the rest home were not interested in how painfully Mr A died or how long it took him to die, as long as it was not revealed to the family or the public.

Ms B also suggests that the rest home's account of events is in many instances not truthful.

## Responses to Second Provisional Opinion

*The rest home*

In response to my second provisional opinion Ms N, Director of Aged Care Services at the rest home, noted that nearly three years have elapsed since the events in question and that there have been considerable changes at the rest home in this time. There is a new management structure with an increased number of senior staff. A completely new documentation package has been implemented, which covers policies and procedures on all aspects of care and performance management, and competencies for staff are an integral part of operations.

Ms N considers that these measures more than adequately address the provision of information to persons who hold an enduring power of attorney for a resident. The admission procedure now includes a requirement that any enduring powers of attorney are identified and copies of the documentation obtained. The attorney is then listed as the person to be contacted for any decision that needs to be made in relation to that resident. Ms N advises that there is an "open door" policy for family involvement. The rest home offers monthly or three-monthly reports on residents with information about how they are. Family evenings are held and, as a minimum, the rest home annually invites residents' families to a formal meeting with senior staff. Ms N states that her staff do all they can to encourage family input and notes that these opportunities are often not utilised.

Ms N informed me that the rest home was audited in 2004 by Bureau Veritas Quality International and found to be fully compliant in all areas at audit, and obtained a three-year certification. She also states that the auditors made many positive comments about the care provided at the rest home.

Ms N acknowledges that at the time of the events complained of, there were issues that were not acceptable, but states that these have now been addressed and the overall standard of care has significantly improved. Many of the staff working at the rest home at the time are no longer employed there. She notes that the rest home complied with the requirements

in my first provisional opinion, attended mediation and unreservedly apologised to the family. Ms N queries what more the rest home can be expected to do and observes that the investigation had been frustrating and stressful for staff. Ms N informed me that she considers that a recommendation to the Ministry of Health that it carry out a further audit of the rest home would be unfair and unreasonable.

**Mr A's family**

*Ms B*

In response to the "information gathered" section of my second provisional opinion, I received a response from Ms B which included a sworn statement. Where her response disputes facts set out in the "information gathered" section of my opinion, I have included the response there. Those responses that raise other matters or are of a more general nature are set out below.

Ms B states that there has been an appearance of bias and significant resistance to information provided by her family. She was also dismayed that I had not accepted her recollection of facts in my second provisional opinion, and for this reason has chosen to provide a sworn statement.

Ms B considers that by claiming his death was inevitable, the providers have abdicated responsibility for his injuries that could have been prevented. In her view, Ms N's statement that such events are unlikely to occur now is evidence that they were preventable in the first place.

Ms B states that she expected my expert advisors to have access to complete information, be up to date, and have appropriate questions asked of them in order that fair, medically sound judgements are made which are consistent with the Code and appropriate standards of practice. She states that she has not found this to be so.

Ms B considers that in the second provisional opinion there is a complete absence of recognition of the need for preventative care. She also criticises my expert advisors for not addressing the issue of preventative care in relation to pressure ulcers, the risk of falling and the cause of Mr A's fractured ribs. In Ms B's opinion, material has been used selectively to support a certain opinion and not to address her father's rights under the Code. She considers that issues about minimising harm have been completely ignored and that only the management of the sacral wound once it developed has been considered. Ms B suggests that the "naïve avoidance" of the issue of preventative care serves to simplify the complaint process. She has provided material about steps that should be taken to prevent pressure sores and also suggests that the dressings used by the rest home in the early stages of the sacral wound were inadequate.

Ms B is of the view that the wound developed as a result of direct pressure and does not believe that there was a sinus that broke down. She considers that her father should have been admitted to hospital for treatment of the sacral wound. She also remains concerned about the events surrounding her father's admission to hospital. Ms B considers that more

should have been done sooner and that her father suffered unnecessarily owing to the failure to provide oxygen.

Ms B considers that the falls on 9 and 16 July were not adequately documented and is concerned that no medical review was obtained by the rest home. In her view, much attention has been paid to Mr A's fall on 19 August but virtually no attention paid to the other falls.

Ms B considers that responsibility for the rib injuries needs to be addressed and that a blind eye is being turned to the duty to effectively prevent injury. In her view, the fact that the fractures occurred while her father was in the rest home's care means that the rest home is responsible for causing the injuries. There was either a deliberate lack of documentation or documents were withheld in case it was seen as negligent. In her opinion I should have obtained a radiological review of Mr A's X-rays.

Ms B considers that my second provisional opinion condoned treatment that produces injuries and suffering. She suggests that my expert advisors have referred to material selectively while information that she has provided from an "impartial specialist" has been completely dismissed. She is concerned that the family is seen as having less credibility than the rest home staff, and this is why she obtained a second report from Dr M. Ms B states that following my GP expert advisor's advice, and dismissing Dr M's reports, represents significant bias.

*Ms F*
Ms F informed me that she felt absolutely devastated that the prevention of Mr A's fractured ribs was not addressed in my provisional opinion. She also states that in her view pillows were not used properly to assist in pressure area care by keeping him off his back and stopping his knees resting against each other.

*Ms D*
Ms D is concerned that the family were allowed to take Mr A home for his birthday on 27 September. She considers that such a trip was inappropriate given the severity of his sacral wound.

*Ms C*
Ms C informed me that in the days before his admission to hospital Mr A told her "that bad things were being done to him" but could not discuss them because he became upset and had difficulty speaking clearly. She states that on 27 October she intended to have her father removed from the rest home.

She states that it is upsetting to know that she and her sister did their best to warn me of the neglect suffered by her father and that I have done nothing to ensure the welfare of the residents at the rest home. Ms C remains concerned that the rights of the elderly are still not being taken seriously at the rest home.

## Independent advice to Commissioner

*General practitioner advice*
The following independent expert advice was obtained from Dr Keith Carey-Smith, general practitioner:

"**Did [Dr G] provide services with reasonable care and skill to [Mr A]?**

(see Conclusion):

**In particular:**

**FALLS:**

- **Did [Dr G] adequately assess [Mr A] following his fall in August?**

The notes made by [Dr G] and the nursing notes at the rest home confirm the summaries by [Dr G] and [the rest home] and indicate that [Dr G] first saw [Mr A] two days after the 19 August fall. In the interim the notes indicate minor injuries only, with no cause for concern, and no mention of chest pain or other complaints from [Mr A]. The rest home notes suggest that [Dr G] was notified the day after the fall, and chose (presumably because there was no concern expressed) to visit the next day (21/8/02). At that time full notes in [the rest home] records (supported by her own notes) indicate an enquiry about the history of the fall (including whether knocked out) and subsequent condition, and an adequate examination of the body parts reported as injured. In the absence of any other complaints or change in his condition during the two days following the fall, I consider this assessment and examination to be adequate.

- **Given the clinical information available in late October, comment on possible causes of [Mr A's] broken ribs (specifically the possibility of a second fall in September, or spontaneous fracture or by coughing)**

There is no indication of the cause of the rib fractures and I can only speculate on possible causes. The recorded fall could have caused the fracture, but I would expect chest pain complaints immediately following the event. Spontaneous rib fractures are unusual, unless 'pathological' (due to a bone abnormality such as cancer deposit). I have never seen a case of rib fracture due to coughing and presume this cause is also unlikely. The lack of mention of chest pain in very full nursing notes over some months, or reported by relatives, suggests a long-standing fracture which had not healed. Fractured ribs are in my experience often found incidentally on chest x-rays with no obvious cause, but presumably due to a fall in the past. Such fractures can be asymptomatic, particularly in immobile, elderly or debilitated patients (as in this case). A second fall is possible, but unlikely, again because of the lack of complaint of chest pain in a man who was apparently able to communicate his needs and symptoms adequately. It is in my view likely that the rib fractures are unrelated to the terminal pneumonia, despite being on the

same side. Hospital records (including the death certificate) do not indicate that the clinicians thought the rib fractures were the primary cause of the pneumonia.

No research information is available to me regarding the likelihood of spontaneous or cough-related rib fracture, however standard texts indicate that ribs can fracture easily in elderly patients, even with minor trauma. It is unlikely that the exact cause can ever be established in this case.

## SACRAL WOUND

- **Should [Dr G] have physically examined [Mr A's] sacral wound prior to 4 October 2002?**

[The rest home] records indicate that a small coccyx sinus was noted on admission in May 2002, and that the sinus started to break down on 9 August. Nursing management was instituted appropriately. [Dr G] first became aware of the sacral ulcer on 21 August 2002. There would have been no reason to request her opinion at this early stage since sacral pressure ulcers are common and managed primarily by nursing staff. The full documentation provided indicates careful expert ulcer prevention and care management by [the rest home], and this is confirmed by the report from [the wound case coordinator] dated 12/11/02.

It would be appropriate for [Dr G] not to examine the wound initially since dressings are designed to remain in situ without disturbance. [Dr G] appeared to have trust in the skills and expertise of the nursing staff; in my opinion the notes and protocols support a high level of care. Although not viewed on 21 August, a bacterial swab was ordered, thus allowing appropriate antibiotic[s] should infection develop. The various explanations provided by [Dr G] are valid. She visited regularly, and received reports, being reassured on 13 September that the wound was improving. Apparently she was not asked to see [Mr A] again until 4 October (apparently requested because of [Mr A's] mental state). At this stage the wound had deteriorated, and she viewed the ulcer for the first time and ordered appropriate further management including antibiotics.

Earlier examination of a wound with no obvious surrounding inflammation to suggest infection would not have changed management in any way, since all possible measures to encourage healing and prevent deterioration were already in place. My own practice in this situation would be similar to that of [Dr G]. Although I prefer to view such wounds even if it necessitates taking down a dressing, in practice wounds are often left undisturbed when I am confident that the nursing staff are competent.

Pressure ulcers of this type are an inevitable aspect of the gradual deterioration in terminal conditions such as Parkinson's Disease, and in my opinion, do not normally heal spontaneously however expert the care, or respond to surgical intervention. Expert nursing care and appropriate medical treatment can only slow the inevitable progression.

- **Did [Dr G] reasonably manage [Mr A's] medication, in relation to his sacral wound?**

As mentioned above, good nursing care with appropriate dressings, adequate hydration, and appropriate use of antibiotics for significant infection, can slow the process of deterioration. Limiting the immobility of Parkinson's disease with appropriate medication is also important, and was clearly being addressed in [Mr A's] case. Analgesics sufficient to bring relief are appropriate even if they lead to increased immobility (in this case the prescribing of Kapanol on 14 October is considered reasonable). There are no other medications that would be likely to make any difference in this case. I consider [Dr G's] management of medication appropriate.

- **Did [Dr G] take reasonable steps to ensure that [Mr A] received coordinated care in relation to his sacral wound, including appropriate reviews by wound specialists?**

Sacral pressure sores and ulcers are common in immobile and elderly patients, and most appropriately managed by primary care nurses, with assistance from general practitioners. If available, a specialist wound care nurse or consultant in care of the elderly would be involved in the more complex cases, or to ensure all possible measures are being taken when deterioration occurs. Although surgical intervention is sometimes successful in the less debilitated patients, eg by grafting a clean superficial ulcer in a stable bed-bound patient, in this case there was no clear benefit to be obtained from a surgical referral. Surgical debridement sometimes improves infection risk and odour, but again in this case was unlikely to influence overall wound healing. However, it would be appropriate to request a surgical opinion if there is any question on the part of doctor, nursing staff, patient or relatives, that management was not optimal. The difficulties and costs in obtaining such an opinion (often as a private consultation) tends to discourage most general practitioners from proceeding unless clearcut benefit, or strong family or patient pressure, is present. Clearly a surgical referral was considered by [Dr G] as discussed in her letter (p 3).

In conclusion, I consider that in this case deterioration appeared inevitable, all appropriate measures were being taken, and surgery was not indicated. Therefore failure to obtain a surgical opinion was not a significant deficit in care. The geriatrician was consulted by phone according to [Dr G]. Unfortunately the wound care specialist nurse was away, and I presume no deputy was available. If called, she could have advised on dressings, debridement, etc, but her report indicates that in retrospect the nursing care was appropriate. Overall wound care at [the rest home] appears to have been well coordinated, and outside consultation used as far as was reasonably possible, available, and necessary. The sacral ulcer is unlikely to have been a primary cause of [Mr A's] eventual demise.

**What information should [Dr G] reasonably have conveyed to [Ms B] regarding her father's condition and care?**

It would be appropriate that the following information be conveyed to [Mr A's] closest relatives (either directly by [Dr G], or via nursing staff at the rest home):

- The overall condition of [Mr A] as incurable and probably terminal
- The likelihood, with increasing immobility and debility, of complications, in particular worsening of pressure wounds, and the development of terminal pneumonia
- The need to decide on the level of intervention or resuscitation appropriate, given the likely negative eventual outcome. The question of when or if admission to hospital was appropriate might also be discussed.
- The chronic and probable deteriorating nature of pressure ulcers, and the nursing care necessary to avoid infection and reduce the risk of extension. The need for appropriate analgesia, even if this produces drowsiness and immobility.
- Agreement to notify nominated relatives of any significant or rapid deterioration in condition.

It is likely that there would be an expectation by [Dr G] that [the rest home] nursing staff would be communicating about the day by day condition including state of the ulcer. The records in fact suggest that their communication was satisfactory (see also remarks on last page).

## CONCLUSION

**Did [Dr G] provide services with reasonable care and skill to [Mr A]?**

Overall, I consider [Dr G] managed [Mr A's] medical care, both before and during the terminal period, with a high level of care and skill, and communicated appropriately as far as was possible with other health professionals and relatives.

**Are there any aspects of the care provided by [Dr G] which warrant either:**

**Further exploration by the investigation officer?**

Nil

**Additional comment?**

It should be noted that the standard of recording and documentation by both [Dr G] and [the rest home] was high, and allowed me to determine my opinion with confidence and accuracy.

An important generic issue in this case is the difficulty in communication between GPs and relatives inherent in rest-home care of patients.

- There is usually an assumption by the GP that the rest-home staff are communicating regularly with the relatives, both concerning their own observations, and about the results of any medical intervention or doctor's visits. In my experience, this assumption is usually correct, and appears to be so in this case also.
- Ideally, the relatives should be communicated with directly (either by phone or by making a specific appointment) when a significant change or need for decision arises, even if this necessitates further time and cost. In fact in this case [Dr G] talked to a relative at his rooms when the deterioration became evident.
- Relatives are usually not present when the GP visits the rest home, and it is difficult to arrange this unless relatives are free to spend some time at the home.
- There are complex issues of privacy and confidentiality of information, such as knowing which family members to communicate with (depending on the patient's wishes), what to share with or withhold from the relatives, and what to share with or withhold from the patient.[9] It is therefore not always possible to manage this whole area without occasional mistakes, or without causing dissatisfaction to one or more parties.
- In this case, concerns might have been addressed, and the complaint avoided, if clearer communication channels between GP, rest home and the several relatives, had been in place throughout."

*Nursing advice*
The following independent expert advice was obtained from Ms Jan Featherston, registered nurse:

"**BACKGROUND:**

[Mr A] was admitted to [the rest home] on the 25th May 2002. He had a history of Parkinson's disease, dementia and constipation and incontinence. [Mr A's] GP was listed as [Dr I], but his care was taken over by [Dr G] in June 2002.

The nursing clinical notes consist of a Resident Lifestyle Care Plan.

This documentation is three pages of assessment details

Entries on page one, are documented about

- Name
- NOK [next of kin]
- Address
- Phone

[9] The Commissioner notes that under Right 6 of the Code all patients have the right to the information that a reasonable patient in their circumstances would expect to receive. Communicating with family members where one holds an enduring power of attorney is addressed later in this report.

- Allergies
- Doctor
- Date of admission
- Religion
- Diagnosis
- Nursing alert
- Hygiene Needs including goals and interventions
- Oral Hygiene including goals and interventions
- Pressure area care – this includes an assessment score and risk level

Page two includes

- Food and fluids
- Dressing
- Elimination
- Mobility includes a fall risk assessment score

Page three includes

- Sleep
- Social/cultural and spiritual preferences
- Individual daily routine preferences
- Activity preferences
- Family and Whanau needs

All pages of the resident Lifestyle are completed appropriately. The Goals and interventions demonstrate that staff had carried out an individual assessment of [Mr A] on admission. There is a signature by the assessing Registered Nurse.

This type of assessment is very typical of what is found in many aged care facilities.

The nursing progress notes start on the 26/5/02 with an entry:

*'A super chap assisted with shower and other care. Please assist teeth cleaning. Likes to use bottle to PU. Eating well and appears to be settling in well'*

This entry is signed but no staff designation is listed beside the signature.
The entries in the nursing progress notes document care on a fairly consistent basis each shift for the time that [Mr A] was a resident at [the rest home].

Other supporting documentation is what appears to be a care plan. This identifies two issues:
- Ulcer on Sacrum
- Weight loss

There is a goal and interventions listed.

At the bottom of the page there are dates and signatures 15/8/2002, 12/9/2002, 1/10/2002.
The intervention would be appropriate for the support and goals listed.

Also included is a Specialised Plan of Care.
This form relates to weight loss and includes supplements that are required for care.

There are two short-term care plan pages attached. One documented on 15/8/02 and it lists the problem of breakdown of skin on sacrum.
There are four interventions listed and an evaluation dated 1/10/02.

The second dated 12/8/02 and lists weight loss. There are interventions and an evaluation dated 12/9/02.

A consent form is included and is signed by two family members and a witness. There is no date on this form.

A one page Physical Restraint Consent is presented. It is dated 26/8/2002.
It lists the type of restraint as seat restraint.
It appears to be signed by the doctor on the 26/8/02 and family member on the 27/8/02.

There is also presented an attachment of forms that relate to wound care and an accident/incident report. Comments on these forms will be included in opinion.

**FALLS:**

- **Was [Mr A] adequately reviewed following his fall on 19 August?**

The nursing progress notes on the 19/8/02 state:
*'Eating quite well today. [Mr A] very stiff and bent ….(Difficult to read) Toppled out of chair at lunchtime resulting in a contusion to (L) side of forehead. Family notified. Now resting on his bed.'* This entry is signed.
The next entry is also dated 19/8/02 and signed.
*'Remains on bed this duty after shower E&D quite well, steri strip applied to forehead contusion mod amount of bruising present, HPU.'*

The next entry is from the night staff who wrote, *'slept well'*
The next entry is listed as *'A.M'*
*'Leakage at changeover washed and dressed. E+D very well but had to be fed. Supp after lunch. Had good result. Dressing to sacrum changed. L knee painful and looks …[diff to read] [Dr G] notified. Paracare @ 12.30 for pain.*
*BNO Bowel full Glye supp + manual removal – large result.'*

*PM 'Sacral dressing intact. Not reviewed by doctor this PM re knee & fall joints stiff but settled comfortably HNPU BNO. Pad insitu'*

On 21/8 the am staff documented:
*'Washed and dressed before breakfast HPU BNO Sitting in his room between meals E+D small amounts with assistance*
*S/B [Dr G], Madapar med adjusted*
*For blood test*
*Wounds swab and neat dressing please.'*

An incident form is completed and dated the 19/8/2002. It lists the patient's name and time of accident at 1310hrs.
The description of accident is listed as:
*'[Mr A] was leaning forward in his wheelchair and over balanced and fell to the floor'*
The extent of injuries:
*'Contusion to (L) forehead.'*
Treatment given:
*'Head cleaned – [Mr A] reassured and placed on his bed to rest'*
Staff have documented that they contacted the family –
Page two
Follow up action
*'[Mr A] is to be positioned where he is observed by staff at all times. Lap restraint 26.8.02 consent form activated'*
Remarks:
*'[Mr A] checked regularly for concussion 20min intervals'*
Further action to be taken:
*'20/8/02 Please ask for GP review, as [Mr A's] condition appears to be deteriorating. Please ensure that [Mr A] is observed at all times ?action restraint*
*26/8/02 Restraint (lap) activated at request manager, family and GP have signed request pt to be visual at all times. Please check 20 min intervals.'*

This form is signed at the bottom by the manager on the 26/8/02.
It is my opinion that [Mr A] was adequately reviewed following his fall on the 19 August. I have formed this opinion based on the documentation that was provided. There are two issues that could have been assessed and/or documented more appropriately. Those being a full set of neurological observation such as level of consciousness. Staff state that [Mr A] was checked for concussion but they do not elaborate on what assessment they took, if any.

The other issue is a full range of movement assessment; this would include examining limbs and asked the question has the fall affected any range of movement in any limbs?
There was appropriate follow up action to prevent this type of fall happening again.
Family were notified at an appropriate time.

- **Should they have sought a GP review sooner?**

[Dr G] was notified on the 20/8/02 as evidenced in the nursing progress notes. Nursing staff had carried out an assessment and documented what injuries they had found. They had treated the injuries appropriately. It is documented in the nursing progress notes that it was not until the 20/8/01 that staff noticed increasing pain in L knee. It appears at this stage that it was appropriate to call the GP.
In [Dr G's] letter dated 25 March 2003 (page 2) she states that:

*'I attended him following a fall on the 21/8/02. He had a bruise and laceration to his left forehead and bruising to his left shin. He had not been knocked out and there was no evidence of other bony injury. Specifically there was no complaint of chest pain or any difficulty breathing.'*

It is my opinion that staff acted appropriately in requesting medical help. I have formed this view on the documented evidence presented.

- **Did they take appropriate steps to prevent [Mr A] suffering falls?**

I am of the opinion that staff did take appropriate steps to prevent [Mr A] falling. There is evidence that staff requested that [Mr A] be positioned where staff could observe him at all times. The Manager also requested that staff check at 20min intervals.

**SACRAL WOUND:**

- **Did they arrange appropriate medical reviews of [Mr A's] sacral wound and/or general condition?**

The wound care form first indicates that [Mr A] had a broken area on his sacrum on 9/8/02.
The Position and Description of Wound is listed as:
*'Broken area sacrum'*
Dressing instructions:
*'Cleaned c/o $H_2O$ covered Allevyn Adhesive'*
The wound care form indicates that it was reviewed on the 11/8/02:
*'Dressing dislodged redressed c/o adhesive allevyn'*

A more thorough wound assessment chart was completed on 1/10/2002.
It outlines that the wound was black in colour, moderate exudate, wound edges were dusky red, full thickness, the wound base was firmly attached, surrounding skin was red, maceration in one area, no temperature, odour was present, pain – not expressed, dressing type was listed.

The Medical Officer first documented [it] in the medical notes on 21/8/02. [Dr G] states that she did not see the wound as it was recently dressed, but she did inspect the area

around the wound. This practice would be considered normal if the nursing staff indicated the wound was healing.

On the 13/9/02 staff informed [Dr G] that the wound was healing and again she did not observe it. It was not until 4th October that [Dr G] saw the wound.

It is my opinion that nursing staff should have sought the advice and observation of the wound by the medical officer. In saying that there may not have been a change in any dressings or interventions used, but it would have ensured the medical officer was fully aware of the situation.

- **Should they have sought a review by a specialist wound care nurse, prior to 4 October?**

In light of the deteriorating nature of the wound and despite appropriate intervention the wound showed no sign of improvement, in fact it continued to deteriorate. A specialist wound care nurse would have been appropriate sooner. If only to support the staff in their decision making. The outcome may not have been any different as [the IV & Wound Coordinator at the DHB] indicated in her review that:

*'Appropriate dressings were being used at [the rest home]and provided optimal wound bed environments'*

- **Did they appropriately treat the sacral wound? Including the use of:**
  **Dressings**
  **Pressure relieving devices**
  **Medications**
  **Wheelchairs**

It is my opinion that the documentation that [the rest home] presented in relation to dressing types, pressure relieving devices and wheelchairs would have been appropriate intervention[s] for [Mr A]. Patients with multiple medical conditions such as his are very difficult to nurse. His obvious resistance to nursing cares and meals made his cares a challenge. There is documented throughout the nursing progress notes that staff turned, washed, and provided mouth cares for [Mr A].

The chair (pictured) which [Mr A] used, is designed as a very comfortable chair in which patients can have their position changed without transferring to other chairs. It would also have given the staff the ability to move [Mr A] around the hospital environment to ensure that he was monitored closely as indicated in the care plan.

Medications – It is not my area of expertise to comment on the appropriate medications. I think there is enough evidence from specialists and consultants to say that there was ongoing monitoring and evaluation of this.

My comment would be that there was no thorough nursing assessment and evaluation of pain. It is well recognised that the frail demented elderly present pain in many different ways.

**BROKEN RIBS:**

- **Should they have identified [Mr A's] broken ribs?**

The first mention of sore ribs is in the nursing notes dated 14/6/02
*'C/o pain at bottom of ribs? Coughing'*
The next frequent group of entries in the nursing notes that indicate [Mr A] was frailer than usual are around the time of his fall on the 19/8/02.
*28/8/02 –'very stiff and frail'*
*29/8/02 –'decreasing mobility and posture'*
These comments are in line with a patient who has end stage Parkinson's.
There is nothing else in the nursing progress notes to indicate that [Mr A] had sore ribs.
The notes indicate that staff provided care in relation to pressure area care and in doing so would have been required to turn and reposition [Mr A] regularly.
Therefore it is my opinion that there is nothing clinical to indicate that [Mr A] had fractured ribs.

- **Given the clinical information available about [Mr A's] condition in late October, is the explanation given by [the rest home] a possible reasonable explanation for the cause of [Mr A's] broken ribs?**

A medical officer would answer this question more appropriately.
From my nursing experience it is possible to fracture ribs or bones spontaneously especially if a patient has severe Paget's disease, Osteoporosis or any disease such as cancer, which affects the bones.

**REFERRAL TO HOSPITAL:**

- **Should they have provided [Mr A] with oxygen?**

The clinical notes indicate that on the afternoon of 26/10/02:
*'All wounds redressed after shower. Turned regularly mouth cares given. Eating small amounts HPU – 400mls in urodome. Chest sounding clear'*
The night shift on the 27/10 states:
*'Turned at 0230hrs & changed pad resettled'*
The morning shift states:
*'Washed and changed after breakfast then taken out to the room. Ate quite well at breakfast. Mouth cares given became acutely unwell at lunchtime chest very noisy – copious thick sticky mucus present in mouth and throat placed in recovery position to ease distress. On call GP contacted to visit. Then advised by […] her car had broken*

*down and to contact ambulance. [Ms D] notified of [Mr A's] condition and was present at time of transfer.'*

[Ms H] indicates in her letter that [Mr A's] condition started to deteriorate rapidly. That a nurse stayed with the patient, and staff did not give him oxygen due to the copious amounts of fluid that were coming out of [Mr A's] mouth and nose.
If this was the clinical picture and it is indicated in the nursing notes, then it would have been ineffective to give oxygen. It is stated that the ambulance officer did try to give oxygen and this had to be discontinued due to excess fluid from [Mr A's] mouth and nose.

- **Did they seek appropriate medical assistance?**

There is evidence that staff contacted the medical officer as soon as [Mr A's] condition deteriorated. The sequence of events led to a delay in the medical officer arriving but that was no fault of the facility.
The usual sequence of events is to call the medical officer and for the medical officer to arrange an admission to hospital. The nursing staff must use their professional judgement on whether to call an ambulance if there was to be a delay in the medical officer arriving.

- **Did they seek medical assistance in a timely manner?**

It is my view that the facility did seek medical assistance in a timely manner.

- **On the basis of the evidence available, what information should [Ms H] and other staff reasonably have conveyed to [Mr A's] family regarding his condition and care?**

There is evidence through the notes that the family visited regularly and that staff discussed [Mr A's] condition with them. What is also difficult to assess is that what one person says may be interpreted in a very different manner from what is accurately said. I could not see through the notes a full multidisciplinary team meeting, which should have included the family. These meeting are invaluable to address family concerns and it also allows the family to ask any questions in relation to care which one of the team could have answered. A meeting such as this should be documented and the family given a copy should they request one.

It also allows the facility to discuss the goals for care and the care outcomes.
This case highlights how nurses, on the one hand, think they have communicated well with families and, on the other, families feel they have not been informed.
Nursing staff should document very clearly what they discussed with families and also which family member they talk to. I am of the opinion that the notes show there was communication but do not go into depth as to what was discussed.

**SUMMARY:**

As discussed the documentation presented for the care of [Mr A] was adequate to demonstrate what the staff did, and the actions they took. It is my opinion that staff did meet a reasonable standard of care.

As stated by the wound care specialist, [Mr A's] frail physical condition would not have assisted healing and would have in my opinion comprised any healing that was taking place. His diet was poor and he was at times a challenge for the staff to care for.

Communication between the family and staff could have been improved by having family reviews, which included the medical officer."

*Further nursing advice*

Further expert advice was sought from Ms Featherston regarding the management of [Mr A's] medication:

"I have been asked to provide further advice around the issues of medication in relation to the care of [Mr A].

I have reviewed the full documentation that was sent and reviewed my original opinion in relation to care.

I wish to note that my opinion is based on a nurse's knowledge and skills. I am not a pharmacist or a doctor and hence am not qualified to give a clinical opinion on the medications charted but have based my opinion on what would be normal nursing practice in long-term care for the elderly.

*Did staff give [Mr A] the correct medication and in the correct doses?*

Firstly, I wish to comment on the written medication sheet – The first drug sheet shows that the medications were charted on 30/05/02. This includes
Selegiline, Asprin and Madapar. These drugs were charted on the long-term drug chart.

The same day on the short course chart the medical officer charted
Codalax Forte, Quinine Sulphate, Temazepam and Panadol.
The medication administration sheet would indicate that the correct medication was given. The only comment I would make is that other medications were given. They included Lactulose and Cough mixture was administered 6 times. The first time was on 6/6/02. It was not documented in the nursing progress notes as to why this medication was administered or what assessment had taken place. It is also difficult to assess whether this was given by a registered nurse or by a caregiver as no designation is listed beside the signature.

The night staff reported that [Mr A] was coughing on the night of 7/6/02; no medication was administered that night. Again on the 10/6/02 the nursing progress notes report that [Mr A] was coughing and was administered cough mixture. Again it is difficult to decide who administered this as no designation is listed beside the signature.

Lorazepam was charted on the medication sheet. It is not dated, but was first administered on 20/6/02. The nursing notes indicate that [Mr A] was disruptive on 20/6/02 and the staff contacted [Dr G].

Lorazepam was again administered on the 21/6, at 08.30am and 2100hrs, 25/6 19.00, 26/6 19.00, 29/6 02.15, 9/7 12.30 and 2100hrs, 10/7 21.00hrs, 12/7 08.45am and 21.00hrs, 15/7 09.00hrs, 16/7 09.00hrs, 17/7 09.00hrs.
There is some discrepancy in the nursing progress notes and the drug chart.

The entry on the 25/6 states that:
'*Refused to take PM Lorazepam so checked [Mr A] often'*
The drug chart indicates this drug has been given.

On the 26/6 the nursing progress notes state:
*'Please no Lorazepam unless aggressive'*
The PM entry states:
'*Settled well after tea He requested that he have a good sleep like last night so Lorazepam given at 19.00hrs'*

On the 9/7 Lorazepam was administered at 12.30 and 21.00hrs
On the PM shift [Mr A] fell.

The next medication administration chart indicates that four doses of Lorazepam was administered on the 20/7, 21/7, 22/7, 23/7.

The nursing progress notes of the 31/7/02 state:
*'S/B [Dr G] continue with same care. Lorazepam only if necessary'*
There are no other entries in the medication administration record that would indicate that Lorazepam was administered again.

The medication sheet and corresponding administration sheet I found confusing to interpret.

The medication charted on the 21/8/02 should read:
Aspirin 300mg ½ am
Madapar 125mg 2 am, 1 lunch, 1 at supper
Pergolide .05 for 2 days eg 22-23/8
.1mg for 4 days 24-27/8
.2mg for 4 days 28-1/9
.3mg for 4 days 2-5/9

I cannot see a signed medication administration sheet for this medication. The nursing progress notes indicate that [Dr G] adjusted the Madapar. There is no mention of the Pergolide commencing or of the dispensing of this drug.

Also commenced on the 27/8/02 was the broad spectrum antibacterial CIPROXIN
The nursing progress notes of the 27/8 state:
*'GP also contacted a view to ??? ABS'*
The PM notes state:
*'[Mr A] commenced AB's @ teatime'*
There is no record of the antibiotics charted in the medication sheet.
If a verbal order was given to nursing staff it should have been documented in the drug sheet and signed off within an acceptable time frame.
Staff should have also ensured that it was correctly documented in the nursing progress notes.

Pain Medication

Panadol was charted on the 30/5/02 and was given on the
14/6
5/7
9/7
13/7
16/7
17/7 x2
18/7x2
29/7
20/8
9/10
27/9

Panadeine was commenced on the 18/10 and was administered regularly until the 27/10.

Kapanol (morphine sulphate), which is a stronger pain relief, was administered on the 15/10 and 16/10.
The medical officer had identified on the 14/10/02 that:
*'Pain a problem'*
On the 15/10 02 the progress notes state that:
*'…. Given Kapanol after dressing procedure …'*

The nursing progress notes do not outline why the Kapanol was stopped and changes to Panadeine commenced.

**Summary**

It is my opinion that there has been a serious breach in the dispensing of medications in relation to the policies and procedures of the facility and competent good practice. Drugs appear to be given that were not charted. Drugs also appear to not be given that were charted. There may have been other drug administration sheets that were not presented with the documentation.

Assessment – In the event of nursing staff giving such drugs as Lorazepam, a thorough assessment should have been undertaken in relation to behaviour. Patients, especially the elderly, may present in a confused state for a number of reasons, the most common being a urinary tract infection and dehydration. It is not appropriate to give such medication without a thorough assessment of the patient's behaviour or rule out reasons for such behaviour. In saying this it is difficult to interpret the notes as there is no documented designation as to who has written the notes. It is important for each person contributing to the notes to list their designation to identify the knowledge and skill.

Pain relief
In my initial advice I commented that there had been no thorough nursing assessment and evaluation of pain. In reviewing the medication chart and nursing progress notes I support this opinion.
Research available states that patients who have impaired cognitive function are less likely to be treated for pain than those that can communicate their needs.
[Mr A] had a number of medical problems on admission and it was obvious that his condition deteriorated since admission. There was not any nursing assessment in relation to pain and the medication chart demonstrates that limited pain relief was administered. Kapanol is best given as a BD (twice Daily) dose, as this is a long-acting morphine. The progress notes state that that this drug was given after his wound was dressed. It would have been appropriate to give this drug before the wound was dressed to prevent the patient suffering any pain and discomfort.
There are many pain charts that are appropriate to patients who are not cognitively aware. Staff should have carried out a pain assessment in consultation with the visiting medical officer.

It is my opinion that the medication charts are difficult to decipher and do not meet competent practice. Staff must document their designation on completing the nursing progress notes and carry out a documented assessment of the patient's condition to assess the benefit of medication and to ensure the accuracy of drug dispensing."

*Additional nursing advice*
Ms Featherston provided the following additional advice on 29 March 2005:

"I have been asked to provide further advice around the issues of

**Pressure Relieving devices and Referral to hospital for [Mr A]**

*Was it appropriate for [the rest home] staff to continue to provide [Mr A] with an Apollo pressure relieving mattress once his sacral wound had progressed beyond a stage II wound, eventually becoming a stage IV wound?*

I have read the information supplied.

[Mr A's] general medical condition deteriorated rapidly over a number of weeks, this included his skin integrity and his general health. He was difficult to feed and despite dietary supplements his condition continued to deteriorate.

His sacral wound was in my opinion treated appropriately. There are many more factors in providing end stage care for a frail gentleman other than just supplying equipment.

It would have been ideal to provide an air ripple mattress which redistributes air and alleviates pressure to the body on a regular time frame.

In my experience there is no one piece of equipment or one action that would have healed [Mr A's] pressure sore. [Mr A] was frail, had bowel problems, his nutrition and hydration all would have lead to a deteriorating wound. It must also be noted that due to his dementia he was noncompliant in his cares and he would roll back onto his back.

It must be noted that on admission staff found a sinus on his sacrum and it is also my experience that although it may have looked superficial in fact many times there is a deep wound underneath this.

It is my opinion that adequate care was provided to [Mr A].

In an ideal world a pressure mattress which has the ability to relieve stage IV wounds would have been the equipment of choice but it is my opinion this did not have an effect on the clinical outcome.

**Referral to Hospital**

*Given that the ambulance report notes [Mr A's] lips being dry and that the ambulance officer was able to administer oxygen at the rate of 10 litres a minute, should [the rest home] staff have provided [Mr A] with oxygen while waiting for the ambulance to arrive?*

[Mr A's] condition deteriorated quickly. I accept the nursing progress notes that there was '*copious thick sticky mucus present in mouth*'. The nursing staff followed correct

nursing procedure in placing [Mr A] in the recovery position. By doing this in all probability could have cleared his airway. Oxygen should have been given but again this is a difficult call as the registered nurse is on the spot at the time and makes her assessment and carries out cares based on that assessment. It would not have done any harm to the patient to give oxygen. The ambulance report states that [Mr A's] '*blueness around lips – dry'* this would indicate to me that the patient was having some difficulty breathing. Many older frail adults do aspirate food and fluids and also saliva. This can cause distress and shortness of breath. Once the airway has been cleared then it is appropriate to give oxygen just as it is appropriate to place the patient in the recovery position.

In my opinion I find that the care provided to [Mr A] was of a standard that is acceptable and would be provided in the majority of rest homes and hospitals throughout New Zealand."

In a follow-up phone conversation on 29 March 2005 Ms Featherston explained that while it would have been optimal care to provide Mr A with a different mattress specifically for Stage IV wounds, failing to do so did not amount to inadequate care, taking into account the general standards and practices in New Zealand rest homes. Ms Featherston also explained that from the information provided in relation to the events of 27 October 2002, it may have been difficult to administer oxygen initially but it could have been given when the breathing passages cleared. In her opinion failing to administer oxygen was not a failure to provide services of an appropriate standard and she indicated that nurses can sometimes be reluctant to administer oxygen in such circumstances.

## Code of Health and Disability Services Consumers' Rights

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

*RIGHT 4*
*Right to Services of an Appropriate Standard*

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

…

4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

*RIGHT 6*
*Right to be Fully Informed*

*1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*
   *a) An explanation of his or her condition; and*
   *b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …*

*RIGHT 7*
*Right to Make an Informed Choice and Give Informed Consent*

*2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent*

## Professional standards

The following professional standard from the Nursing Council's 'Code of Conduct for Nurses and Midwives' (2004) is applicable in this case:

"Principle Two

The nurse acts ethically and maintains standards of practice.

**Criteria**

…

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

### Health and Disability Sector Standards (NZS 8134:2001)

The following Health and Disability Sector standard is applicable in this case:

"Standard 5.2

Consumer/kiritaki records are accurate, reliable, authorised and comply with current legislative and/or regulatory requirements"

## Opinion: Breach – The Rest Home

*Review of sacral wound*
It is clear that the management and treatment of Mr A's sacral wound was a complex process, which involved a number of people over several months. Under the rest home's wound care policy it is the manager's responsibility to audit pressure area care annually, and the day-to-day management of wounds is the responsibility of the registered nurses. The nurses are specifically responsible for assessing wounds, selecting appropriate dressings, changing dressings, and writing up the wound assessment and wound care forms. Although Dr G was also involved in the management of the wound, it was the rest home's staff, particularly the registered nurses, who were responsible for the day-to-day management of the wound, reviewing its progress and reporting any concerns to Dr G.

I accept Ms Featherston's advice that overall the dressing types, pressure-relieving devices and wheelchairs used, as documented at the rest home, were appropriate interventions for Mr A's sacral wound. I note Ms Featherston's comments that patients like Mr A, with multiple medical conditions, are very difficult to nurse.
I also accept my expert nursing advice that the rest home staff should have sought Dr G's advice, and asked her to observe the wound prior to 4 October. Such an observation should have involved Dr G viewing the wound without any dressings. Ms Featherston advised that since the wound continued to deteriorate, it would have been appropriate for the rest home to have sought a review by a specialist wound care nurse sooner and I accept her advice on this issue.

Staff had been dressing the wound since 9 August. They first brought the wound to Dr G's attention on 21 August. Dr G did not sight the wound, as dressings had recently been applied and it was preferable not to disturb them in order to promote healing, and staff assured her that the wound was improving. On 13 September Dr G was again reassured by staff that the wound was improving. Between 13 September and 4 October Mr A's wound obviously deteriorated. However, staff did not ask Dr G to review the wound. It was not until 4 October, when Dr G reviewed Mr A, at Ms D's request, that she actually sighted the wound. It had developed into a stage 4 "smelly and nasty" crater, six centimetres in diameter. Furthermore, it was only at this point that the rest home tried to arrange for an assessment by the wound nurse. The rest home informed me that the nurse was unavailable as she was on annual leave. There is no record of this request in the notes and records provided by the rest home, nor is there any indication of any attempts to make alternative arrangements or arrange a review on the nurse's return.

In these situations medical practitioners rely on nursing staff to inform them of any deterioration in the wound. Dr Carey-Smith advised me that Dr G "appeared to have trust in the skills and expertise of the nursing staff" and that "the notes and protocols support a high level of care".

Ms Featherston advised me that "staff did meet a reasonable standard of care". However, in my opinion, in failing to ask Dr G to sight the wound prior to 4 October or arrange review

by a specialist wound care nurse, the rest home failed to take all reasonable steps to minimise the potential harm to Mr A from his sacral wound, and thus breached Right 4(4) of the Code.

I note Dr Carey-Smith's advice that earlier examination of the wound would not have changed management in any way, since all possible measures to encourage healing and prevent deterioration were already in place. In my opinion, while earlier review may not have changed the treatment plan, it would have ensured that Dr G was fully aware of the situation. I also acknowledge Dr Carey-Smith's comments that pressure ulcers are an inevitable aspect of conditions like Parkinson's disease, and that they are unlikely to heal, even with expert care or surgical intervention.

The family are concerned that my provisional opinions did not address the steps that the rest home should have taken to prevent the sacral wound developing. I agree that prevention of pressure wounds is very important and that a number of steps can be taken to reduce the likelihood of such wounds developing. However, the focus (and legal ambit) of my investigation was on the treatment of the sacral wound once it developed, and therefore my report focuses on this issue. Furthermore, it is not clear that the rest home could have prevented the sacral wound developing in the first place. I note that Mr A was found to have a sinus on his sacrum on admission to the rest home in May 2002 – although it was not documented, as it should have been. My nurse advisor commented that in her experience, "although it may have looked superficial in fact many times there is a deep wound underneath this".

*Management of medication*

In a rest home setting, such as at the rest home, the usual procedure for dispensing medications is for the patient's GP to record the medications and dispensing instructions on the patient's Medication Sheet. It is then up to the rest home staff to ensure that the medications are given, and that this is recorded on the Medication Administration Sheet. Rest home staff also are responsible for assessing the patient's medication needs and, if necessary, arranging an appropriate review or referral. Where medication has been prescribed on an "as required" basis, rest home staff must make an appropriate assessment as to the need for that medication.

I accept my expert advice that the rest home failed to administer Mr A's medication according to the Medication Sheet, and that this amounted to a failure to provide services in accordance with good practice. I note that the rest home's services were deficient in several respects.

1) Medications were given without clear rationale. For example, Lactulose and cough mixture were given but the Nursing Progress Notes do not document why this medication was administered, what assessment had taken place, or who had administered it. The antibiotic Ciproxin was also administered, apparently on the advice of Dr G, but was not clearly documented.

2) According to the Medication Administration Sheets, medications that were charted were not given, including Madopar and pergolide. On 25 June, lorazepam was recorded as having been given, although the Nursing Progress Notes record that Mr A had refused the medication.

3) Medications were given without first assessing Mr A to check the potential benefits of the medication. This included not carrying out pain assessments and the use of lorazepam, contrary to the advice in the Nursing Progress Notes that it should only be given if Mr A was aggressive.

4) Pain medication (Kapanol) was given after, instead of prior to, dressing changes. I accept my expert advice that it would have been appropriate to give this drug before the wound was dressed to prevent Mr A suffering any pain or discomfort.

5) Medication records appear to be incomplete and difficult to interpret. I note that the names and designations of staff administering medication are not recorded. Nor do they always record why medications were changed, such as from Kapanol to Panadeine.

6) The rest home did not carry out a thorough nursing assessment and evaluation of Mr A's pain to ascertain and monitor whether he was receiving appropriate pain relief medication. I accept my expert advice that this is an important aspect of caring for elderly, impaired patients, who may express pain in a number of ways.

The rest home failed to administer Mr A's medications with reasonable care and skill in the various respects outlined above. I accept my expert advice that these failings amount to a serious breach of good practice. In these circumstances the rest home breached Right 4(1) of the Code.

*Undocumented injuries*

Several members of the family witnessed bruising to Mr A's head in mid-September. Photographic evidence shows that the bruising to Mr A's head was visible approximately a week later. The family was informed at the time that Mr A had fallen out of his chair. However, the fall was not referred to in the rest home's notes, nor was there an incident report. The rest home has expressly stated that there were no further falls after the one that occurred on 19 August. The family has suggested that this fall was not recorded because the rest home staff did not wish to admit that Mr A was not being appropriately restrained.

I accept that around mid-September 2002 Mr A sustained the bruising to his head shown in the photos provided by the family. However, I do not agree that there is any information indicating that the motivations suggested by the family should be ascribed to the failure to record the injuries, especially as staff did verbally inform family members that there had been a fall. While the information available is not sufficient to conclude if, and when, a fall occurred, I am satisfied that Mr A had visible bruising, the cause of which was not recorded in the rest home notes.

Failing to record such an injury, however caused, constitutes a failure to provide services in accordance with professional standards. The Nursing Council Code of Conduct and the Health and Disability Sector Standards require that patient records are accurate. In an environment such as a rest home, where care is provided by a number of caregivers, adequate and accurate notes are vital to ensuring that care is co-ordinated and complete. It is important to record the nature and cause of any patient injuries so that they can be properly treated and any necessary steps taken to avoid future injuries. In this instance the rest home staff failed to record the bruising to Mr A's head in mid-September. In my opinion this omission was a failure by the rest home staff to provide services in accordance with professional standards, in breach of Right 4(2) of the Code.

*Information provided to attorney*

When Mr A was first admitted to the rest home, Ms C held an enduring power of attorney for his personal care and welfare, which entitled her to receive information and make decisions on his behalf when he was unable to make decisions for himself. Both Ms C and Ms D were identified by the rest home as relatives to whom information could be disclosed, and this was recorded on a consent form. Ms B was also involved in Mr A's care on an informal basis. I note that Mr A was fortunate to have three daughters who were prepared to act and advocate on his behalf.

During the course of my investigation, it has become clear that there were many contacts between the various family members and the rest home and Dr G, which were recorded in the notes. However, the complaint is that Ms C, who held an enduring power of attorney from Mr A, was not kept fully informed. From the information gathered I am satisfied that the rest home staff were aware that Ms C held an enduring power of attorney from her father.

There appears to have been some doubt as to whether the enduring power of attorney had been formally "activated". No formal "activation" is actually required for an enduring power of attorney to come into effect; rather, the attorney is only able to act in relation to the donor's personal care and welfare when the donor is mentally incapable.[10] While many people may choose to go through the formal process of assessing and documenting the donor's mental capacity, it is not this process that "activates" the enduring power of attorney, it is the donor's mental incapacity. Rather than focusing on whether people were aware that the enduring power of attorney had been "activated", the issue is whether they were aware that Mr A was mentally incapable.

Right 7(2) of the Code states that a patient must be presumed competent to make choices about his or her care unless there are reasonable grounds for believing that the consumer is not competent. In this instance, the rest home staff caring for Mr A were aware that he had Parkinson's disease (a progressive neurological disease) and the nursing notes record paranoia, confusion, agitation and aggression. There seem to have been reasonable grounds

[10] The Protection of Personal and Property Rights Act 1988, s 98(3).

for the rest home staff to believe that Mr A's competence was at least diminished; that he was not completely able to make informed choices or give informed consent; and that they should therefore look to a person who was entitled to consent on his behalf, namely Ms C as his attorney.

Clause 4 of the Code states that for the purposes of Right 6 of the Code, "consumer" includes a person entitled to give consent on behalf of that consumer, such as the holder of an enduring power of attorney. The effect of this provision is that the attorney has a right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. I consider that the rest home should have provided Ms C with an explanation of the nature of Mr A's sacral wound, the treatment options for the sacral wound, and any improvement or deterioration. She should also have been more involved in other decisions such as the use of restraint.

I accept that the rest home staff did provide some information to Ms C about the sacral wound. However, she was not made aware of the seriousness of the wound or the treatment options being pursued, told about the availability of expert advice, or given an accurate prognosis for the wound. I acknowledge that communication was made more complicated by the fact that a number of Mr A's family members discussed his care with the rest home at different times. I also note Dr Carey-Smith's comments that, in these complex situations, it is not always possible for providers to manage communication without occasional mistakes, or without causing dissatisfaction to one or more of the parties. However, even where multiple parties are involved, there remains a responsibility to ensure that the attorney is fully informed.

In summary, the rest home staff had reason to believe that Mr A's competence was diminished. There was accordingly an obligation to provide Ms C, as Mr A's attorney, with full and accurate information about his condition and options available. I accept that information was provided to various family members, including Ms D, who was noted on admission as being someone to consult about Mr A's care. However, none of the family was fully aware of his condition, and several family members have emphasised that the severity of the sacral wound became apparent only on Mr A's admission to the public hospital, and was a complete shock to them. More particularly, the information provided to Ms C fell short of the full and accurate information that she had a right to receive. In my opinion, the rest home has breached Right 6(1) of the Code by failing to provide Ms C with full and accurate information about Mr A's condition.

## Opinion: No Breach – The Rest Home

### Treatment of sacral wound

*Use of appropriate medication and dressings*
Although I have found that the rest home's medication management was inadequate, I accept my expert advice that the medications and dressings used to treat Mr A's pressure wound were appropriate. I note that this matter was primarily the responsibility of Dr G and that, on the information available, the rest home staff appropriately carried out Dr G's instructions.

The wound was initially treated on 9 August, when staff noted that the sinus had started to break down. It was dressed with Allevyn Adhesive every second day, as per the rest home's wound care policy. Five days later, Dr G saw Mr A although she did not view the wound.

On 15 August, the wound had deteriorated and was constantly being compromised by Mr A's faecal leakage. The dressing regime was changed to include IntraSite gel. On 20 August, Mr A's sacral wound was noted to have improved. On 21 August, Dr G noted the wound's presence, but did not review the wound itself. She noted that the wound was not healing and had become "mucky". She requested a blood test and a wound swab. There is no record of the results of these tests.
On 27 August, Mr A was started on a course of the antibiotic Ciproxin. Apparently Dr G was consulted about this, although there is no record of who ordered the Ciproxin. On 30 August staff at the rest home reported that they were having difficulty keeping Mr A off his sacrum, and that he was constantly moving around the bed at night.

On 13 September, the rest home staff advised Dr G that the wound was improving. Dr G reviewed the area but did not view the wound itself. On 19 September, staff noted that the wound had deteriorated significantly. It was dressed with Idoflex.

On 4 October, Dr G reviewed Mr A's wound for the first time and put Mr A on another course of antibiotics. Mr A's dressings were being changed twice or three times a day. A urodome was used to try to protect the dressing from urine.

On 14 October, Dr G reviewed the dressings. She noted that the wound was extending, and looked and smelled offensive. Mr A's overall condition was deteriorating. Changes were made by the rest home staff to Mr A's continence-related medication in an effort to address the leakage contaminating the wound. Around 18 October, the rest home staff debrided necrotic tissue from the wound.

My expert advisor, Ms Featherston, advised me that the dressing types used by the rest home were appropriate interventions for Mr A. The wound care nurse who reviewed Mr A's wound management, commented that the rest home used appropriate dressings (Allevyn and Hydrogels), which provided optimal wound bed environments. Both the wound care

nurse and Ms Featherston commented that Mr A's condition, especially his lack of mobility caused by his Parkinson's disease, made it more difficult to care for his pressure wounds.

I accept my expert advice. In my opinion, the rest home staff used the appropriate dressings and medications on Mr A's pressure wound and did not breach the Code in respect of this matter.

*Prevention of falls*

When Mr A was first admitted to the rest home, staff undertook a full assessment of him in accordance with its policies. This assessment included Mr A's risk of falls, which was assessed as "high". The staff then formulated strategies for reducing this risk, including having two staff members assist in moving Mr A, and taking care when standing Mr A up. These are documented in Mr A's care plan. Ms Featherston has advised me that in her opinion, the steps taken to prevent Mr A falling were appropriate.

I have noted Ms B's views that further assessments should have been done and other preventative measures, such as use of restraint, put in place earlier. I have also been mindful of the fact that restraint is recognised as being a serious and intrusive intervention which is only considered appropriate in limited circumstances, including where an individual's behaviour indicates that she/he is seriously at risk to self or others.[11] As noted in the New Zealand Standard for Restraint Minimization and Safe Practice, "restraint is a serious intervention that requires clinical rationale".[12]

Following Mr A's fall on 19 August, staff reviewed their plan and sought consent from Mr A's daughters to restrain him with a lap-belt in his chair. It was also noted that Mr A should be checked at 20-minute intervals. Four members of the family informed me that the clip on the lap-belt was faulty and on at least one occasion the restraint had to be knotted. I was also informed of an occasion when a family member considered the restraint to be too tight. While the fact that the clip on one of the restraints was faulty is relevant to my considerations on this point, it is not in itself evidence that the rest home's care was below the appropriate standard.

The family are of the view that there were two further falls after the restraint decision was made, and that these incidents were the likely cause of Mr A's fractured ribs. The lack of documentation in relation to the bruising to Mr A's head in mid-September means that it is not possible to say with any certainty whether Mr A fell on this occasion and, if he did, whether the cause of the fall was a lack of restraint. I refer to my comments above about the lack of documentation of these injuries.

[11] New Zealand Standard for Restraint Minimization and Safe Practice, NZS 8141:2001, section 3.

[12] Ibid.

The information gathered shows that the rest home staff were aware of the risk of falls and took reasonable steps to prevent falls from occurring. I accept my advice that these steps were appropriate ones to take in the circumstances, even if they were not successful in preventing Mr A's fall on 19 August and possibly further falls in mid-September and October. I am satisfied that the rest home took reasonable steps to assess Mr A's risk of falls and prevent falls from occurring, and did not breach the Code in respect of this matter.

*Fall of 19 August*

I accept my expert advice that, following Mr A's fall on 19 August 2002, staff at the rest home took appropriate actions to review his condition and seek medical attention in a timely manner.

Directly following the fall, staff assessed Mr A and noted that he had suffered a contusion to his forehead, which was treated. No other injury was noted at the time. Mr A was put under close supervision for concussion and, to prevent further falls, staff arranged for Mr A to have a lap-belt on his chair. The fall and follow-up are well documented in the progress notes and on an incident form filled out at the time.

The next day, when staff noted that Mr A's left knee was painful, they notified Dr G, who reviewed Mr A on 21 August.

I accept my expert advice that the injuries identified immediately following the fall did not require urgent medical follow-up and that it was appropriate for the staff to continue to monitor Mr A closely. When staff noted that Mr A's knee was painful, they appropriately contacted Dr G.

I note my expert's comments that staff could have recorded additional information following the fall, including neurological observations and a "full range of movement" assessment. However, I am satisfied that staff took adequate steps in the circumstances to assess Mr A and sought appropriate medical review when necessary. Accordingly, the rest home did not breach Right 4(1) of the Code in respect of this matter.

*Treatment on 27 October*

On 27 October, Mr A's condition deteriorated dramatically and he began to experience respiratory distress. The rest home staff responded to his distress by placing Mr A in the recovery position, and calling for a doctor to attend. While waiting for medical assistance, staff decided not to give Mr A oxygen through a mask because of the amount of liquid coming from his nose and mouth. The nursing notes record that there was thick sticky mucus in Mr A's mouth.

The rest home informed me that a staff member was observing Mr A constantly at this point. However, Ms B states that his grand-daughter, Ms E, was left alone with him for some time. When the doctor failed to arrive, staff requested that the medical centre call an ambulance. The family states that they had to repeatedly ask the staff to call an ambulance. I accept my expert advice on this matter: that it was appropriate for staff to contact a doctor in the first instance; that it would be usual practice for the doctor to call an ambulance if

required; and that when the doctor was unable to attend it was appropriate for the rest home staff to contact the ambulance themselves.

I am advised that it was reasonable for staff not to provide Mr A with oxygen, if a substantial amount of fluid was coming from his mouth and nose at the time, as this would have made giving oxygen ineffective. There is, however, information that suggests that the amount of fluid present was not substantial and would not have hindered the provision of oxygen. Ms D and Ms E state that there was only a small amount of fluid and that it did not prevent the ambulance officer providing Mr A with oxygen. Also, the ambulance report notes that Mr A's lips were dry and that oxygen was administered. My expert advice is that the appropriate nursing procedure is to place the person in recovery position and, when the airway has cleared, to administer oxygen. In such situations active and continuing re-assessment should be undertaken of all options for lessening the patient's distress.

I accept that there was some fluid or mucus present in Mr A's mouth and nose, which initially deterred the rest home staff from providing Mr A with oxygen. I also accept my expert advice that it was appropriate for the rest home staff to put Mr A in the recovery position to clear his airway. The information in the ambulance report and the accounts from Ms D and Ms E indicate that when they arrived there was relatively little fluid present (possibly because placing Mr A in the recovery position had cleared his airway to some extent). I accept that oxygen could have been administered at this point, but failing to do so does not equate to inadequate care.

In my opinion, the rest home staff took reasonable steps to seek emergency medical assessment, contact an ambulance and provide treatment to Mr A when his condition deteriorated on 27 October, and accordingly did not breach the Code.

## No further action

*Treatment of sacral wound – placement in wheelchair*
From the information gathered during my investigation it is clear that Mr A was placed in a wheelchair on numerous occasions and taken for walks by his family in a wheelchair. What is not clear is the length of time Mr A was placed in a wheelchair or whether his family were actually encouraged to put him in a wheelchair and take him for walks. The parties involved have very different recollections of what was said and done. Family members have stated that they were encouraged to take Mr A for walks outside. Ms H recalls discouraging the family from taking Mr A out in the wheelchair for walks but agreed to the requests after discussion with Dr G, on the basis that he would be put straight back to bed afterwards.

I am unable to determine the adequacy of the treatment of Mr A's sacral wound in relation to the amount of time he spent in a wheelchair or the encouragement given to his family to take him for walks in the wheelchair. I do not believe that further investigation will provide

any further information that will allow me to determine this issue. Accordingly, I have decided to take no further action in relation to this aspect of the complaint.

*Use of pressure-relieving devices*
The rest home informed me that they provided Mr A with pressure-relieving devices, including cushions and mattresses, and that as Mr A's condition deteriorated he was nursed in a Lazy-boy chair. Ms Featherston advised me that these were the appropriate devices for Mr A's condition; the pressure-relieving mattress used in the later stages of Mr A's care was not ideal but was adequate.

My provisional view was that the rest home used appropriate pressure-relieving devices to help manage Mr A's pressure wound and did not breach the Code in respect of this matter. However, in their responses to my first and second provisional opinions, the family vigorously disputed that such devices had in fact been used. They indicated that none of the family had ever seen any mattress on Mr A's bed other than a standard hospital mattress, and provided me with photos in support of their recollections. They also informed me that they did not see a "Spenco" cushion on Mr A's chair, but had been given a piece of foam for him to sit on. Photos of Mr A sitting on the piece of foam were provided.

The family's recollections conflict with the information in the rest home's contemporaneous notes. In general I consider that contemporaneous records are more likely to be accurate than personal recollections. However, in this instance detailed information from the family casts doubt on whether the rest home records are completely accurate. I do not consider that it is possible to resolve this evidential conflict on the information available. Nor do I consider that further investigation would serve to address this conflict, particularly given the time that has elapsed and changes in staff at the rest home. I am also mindful of steps that the rest home has taken to improve its services and prevent the recurrence of the events complained of. Therefore I intend to take no further action on this part of the complaint.

*Rib injury*
On admission to the public hospital it was identified for the first time that Mr A had fractured ribs. The family complained that the rest home had not identified and treated these fractures earlier. The manager of the rest home informed me that she was surprised to hear that Mr A had fractured his ribs and was unable to explain how the fractures occurred. I note the statement made by Ms B that, on 21 September, she visited her father at the rest home and discovered that "he had a very large resolving bruise on the left side of his head, and a sore right chest". She believes that this was the result of a second, undocumented fall in September 2002, which led to Mr A breaking some ribs.

I note that Mr A's chest pain was first documented in June 2002 as "[complains of] pain at bottom of ribs?". Then on 16 July he is recorded as falling and bruising his lower ribs. There is no other specific reference to chest pain in the notes. Neither of my experts has been able to identify from the information provided when or how Mr A's rib fractures occurred. Dr Carey-Smith commented that, if Mr A had suffered a second fall resulting in broken ribs, he would expect Mr A to have complained of chest pain immediately following the fall. Dr

Carey-Smith also commented that fractures like Mr A's are common in elderly or debilitated patients and can be asymptomatic, often being found incidentally on X-rays with no obvious cause. It is his view that in this case, it is unlikely that the exact cause could ever be determined. Ms Featherston commented that treating Mr A's wound required frequent turning, which should have elicited complaints of pain from Mr A, if he had sore ribs. When Dr G reviewed Mr A on 20 August she found no evidence of a chest injury.

The few references in the notes to chest pain or sore ribs, and the family's recollection of Mr A suffering pain in that area all suggest different timing of the fractures. Having obtained a radiologist's opinion on Mr A's X-ray, Ms B responded to my first provisional opinion by informing me that she now considers that Mr A fractured his ribs a week or two before he was admitted to hospital – ie, October rather than September. A second opinion from the radiologist suggests that there were two sets of fractures, one occurring in October and the other two to three months earlier, ie, late July to late August.

Ms B has expressed concern that the radiologist's opinions have not been taken into consideration and that I have not obtained expert radiological advice. I have in fact considered the reports that Ms B has obtained and agree that they indicate that Mr A fractured his ribs while at the rest home. The reports are also consistent with the advice from my GP expert advisor in suggesting that spontaneous fractures from coughing are unlikely in this instance. However, the issue being investigated is whether the rest home staff (caregivers and nurses) acted appropriately in identifying and documenting the fractures. Obtaining expert advice from a radiologist does not assist me in forming a view on this issue.

According to the second report obtained by Ms B, one set of fractures occurred two to three months prior to Mr A being admitted to hospital, suggesting the fall of 19 August as a likely cause. Dr G was asked to review Mr A after this fall and found no evidence of a chest injury. Even if fractures had in fact resulted from this fall, the appropriate response from the rest home staff was to arrange a medical review. However, the fractures may have occurred at a different time. I do not accept Ms B's submission that the fact that the fractures occurred at all is conclusive evidence of poor care. But the failure to document other injuries does raise doubt as to whether the rest home staff were aware of all Mr A's injuries and responded appropriately.

What is clear is that Mr A had fractured ribs when he was admitted to the public hospital. The cause and timing of these fractures are not known. The older fractures may have occurred as a result of the fall on 19 August but this is not certain. There is no information as to how or when the most recent fractures occurred. I have noted Ms C's observations of what she considered unusual behaviour on 22 October, but do not consider that these observations show conclusively that the fracture occurred on that date. I have also noted my expert advice that fractures can be difficult to identify, and that a failure to identify rib fractures does not necessarily amount to a failure to provide appropriate care.

I appreciate that it is very upsetting and disturbing for the family to find out that Mr A had fractured ribs that had not been identified or treated. However, there is insufficient evidence to conclude when and how Mr A fractured his ribs, and this is relevant in considering whether the rest home staff responded appropriately. The information on this issue is not sufficiently clear for me to form a conclusive opinion. Furthermore, I do not consider that there is any other information that I could obtain that would establish the facts with certainty. Therefore I have decided to take no further action on this part of the complaint.

## Allegations of bias

In Ms B's response to my second provisional opinion, my expert advice has been criticised, with the suggestion that information is used selectively and in a way that favours the providers. It is a serious matter to allege bias in an independent advisor. I do not accept that the advice provided by Dr Carey-Smith or Ms Featherston is biased towards providers. Nor do I accept that my expert advisors can be criticised for not discussing issues outside the scope of the advice requested from them. Both my expert advisors have been nominated by their respective professional bodies as experienced and wise practitioners who are held in good standing by members of their respective professions; neither has hesitated to criticise poor quality care when providing expert advice in previous cases.

I note that the following allegation of bias has also been against the Health and Disability Commissioner:

> "There has always appeared to be a bias and significant reluctance against the information we provided and the way this case has been handled."

This allegation impugns the credibility of the legal advisors and the Commissioner, who, as independent professionals, have assessed the family's complaint and undertaken an investigation in accordance with the legal requirements of *fair* resolution of complaints,[13] and the principles of natural justice.[14]

The allegation is rejected in its entirety.

[13] The Health and Disability Commissioner Act 1994, s 6.

[14] The New Zealand Bill of Rights Act 1990, s 27(1).

## Actions taken

The rest home has taken the following actions:

- An apology has been made to the family for breaching the Code.
- Practices and training in relation to the treatment and medical review of pressure wounds have been reviewed.
- Practices and training in relation to medication management have been reviewed.
- Practices and policies in relation to the provision of information to attorneys and families have been reviewed.

## Follow-up actions

- A copy of this report will be sent to the Ministry of Health with a recommendation that it consider whether, in light of this report, a further audit of the rest home is necessary.
- A copy of this report will be sent to the District Health Board.
- A copy of this report, with all identifying features removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



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