# MLC 2011 Limited

## A Report by the Aged Care Commissioner

## (Case 20HDC01432)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. This report concerns the care provided by MLC 2011 Limited to a man while he was in respite care in 2020.

### Findings

2. The Aged Care Commissioner identified several issues of concern across the man's care, including his pressure injury care and his hydration management and monitoring, which involved care provided by multiple staff. While the Aged Care Commissioner acknowledged that the man was becoming increasingly frail, noting the cumulative nature of the issues with his care, she considered that overall MLC 2011 Limited did not provide an appropriate standard of care. As such, the Aged Care Commissioner found that MLC 2011 Limited breached Right 4(1) of the Code.

### Recommendations

3. The Aged Care Commissioner recommended that MLC 2011 Limited provide an apology to the family for the deficiencies in care outlined in this report.

4. As the residential care facility has changed ownership since the time of events, several recommendations were made for the new owners. These included providing HDC with confirmation that the documentation and policies used at the facility have addressed the deficiencies identified in this report; providing staff education; and conducting audits of pressure injury management and fluid balance management to ensure compliance with expected practice in these areas.

## Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her late father, Mr A, at a care home. The following issue was identified for investigation:

- *Whether MLC 2011 Limited provided Mr A with an appropriate standard of care in 2020.*

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

7. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms B | Complainant/consumer's daughter |
| MLC 2011 Limited | Provider |

8. Further information was received from:

| | |
|---|---|
| RN D | Nurse Manager |
| RN E | Clinical Charge Nurse |
| Ms F | Senior caregiver |
| RN G | Registered nurse |
| Medical centre | General practice |
| District nursing service | |
| HealthCert | Ministry of Health certification service |

9. Also mentioned in this report:

| | |
|---|---|
| Ms C | Mr A's daughter |
| RN H | Registered nurse |
| Dr I | General practitioner |
| RN J | Registered nurse |

10. In-house aged-care advice was obtained from Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A).[1] Further in-house aged-care advice was obtained from RN Jane Ferreira (Appendix B).

## Information gathered during investigation

### Background

11. This report concerns the respite care provided to Mr A (aged in his seventies at the time of events) at a care home. In particular, the report concerns the adequacy of Mr A's pressure injury and fluid intake management, as well as a medication error. Sadly, Mr A died a week after his discharge. I extend my condolences to Mr A's family.

12. Mr A's medical history included type 2 diabetes mellitus,[2] polymyalgia rheumatica,[3] metastatic prostate cancer[4] with widespread bone disease, and back pain for which he was prescribed regular opioid pain-relief medication (OxyContin[5] and OxyNorm[6]). In the month prior to his admission to the care home, Mr A experienced a fall with loss of consciousness at home, following a one-week history of confusion and leg weakness. He was admitted to

[1] RN Johnson-Bogaerts provided clinical advice to HDC prior to the new owner's purchase of the care home.
[2] Diabetes mellitus is a metabolic disease that causes high blood sugar. The hormone insulin moves sugar from the blood into the cells to be stored or used for energy. A person with diabetes either does not make enough insulin or cannot use the insulin effectively.
[3] A rheumatic disorder that causes moderate to severe pain and stiffness in the neck, shoulder, and hip muscles.
[4] Prostate cancer that has spread from the prostate to other parts of the body.
[5] Modified release oxycodone (OxyContin) is an opioid pain-relief medication that releases over 12 hours.
[6] Immediate release oxycodone (OxyNorm) is a fast-acting opioid pain-relief medication that can be prescribed on an 'as required' basis with a minimum dose interval.

a public hospital for treatment of urosepsis[7] with resulting delirium,[8] and threatened spinal cord compression, for which he received dexamethasone and palliative radiation therapy.

*Assessment prior to admission to care home*

13. Following discharge from the public hospital, Mr A returned home to the care of his family, with palliative/district nursing support and personal assistance.

14. The district nursing service reassessed Mr A in his home. The district nurse documented that Mr and Mrs A were 'aware things [were] progressing' and discussed concerns about coping, and the possibility of hospice or a care facility. A palliative care nurse from the district nursing service met with Mr and Mrs A and their daughter, Ms C, to assess Mr A's support needs.

15. At the time of the Support Needs Level Assessment, Mr A was using a four-wheeled frame for walking and needed support and assistance with his mobility. He was experiencing decreased appetite and required prompting to drink, and assistance with eating when tired. The assessment noted that Mr A could be confused at times, experiencing mild delusions and hallucinations, and was unsettled at night. Mr A's support needs were assessed as Level 5 (requiring continual professional nursing supervision and/or continuing medical supervision), and his support needs were identified as: 'Respite ASAP [as soon as possible].'

16. Mr A's GP, Dr D, documented a conversation with Mr A's wife that Mr A was 'slipping slowly, confused at times, has had a fall or two'. At the district nurse visit that day, Mr A was noted to be 'looking very frail, pale and tired, but was alert and joining in conversation' and his appetite was noted to be low. He was planned for admission to the care home for urgent palliative respite care.

*Care home*

17. At the time of these events, the care home was certified to provide rest-home and hospital-level care (excluding dementia and psychogeriatric care) and had a service contract with the District Health Board (Health New Zealand).[9] The care home was managed by a Nurse Manager (RN D) and a Clinical Charge Nurse (RN E) with oversight from a Regional General Manager. The Clinical Manager role was vacant during the time of Mr A's admission.

*Assessment on admission to care home*

18. Mr A was admitted to the care home for respite care.[10] The Admission Checklist — Respite Care requires that the admission form and initial assessment are completed on the day of

[7] An infection originating in the urinary tract.

[8] Delirium is an acute and fluctuating mental state characterised by confused thinking and disrupted attention, usually accompanied by disordered speech and hallucinations.

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

[10] It is unclear whether this admission was intended to be for one or two weeks, as both timeframes are referenced in the clinical record.

admission, with the assessment process being completed during the first 24 hours of admission.

19. The Initial Assessment/Care Plan form was commenced on Day 1[11] by RN J and completed on Day 2 by RN E. The assessment noted that Mr A had a restricted range of movement and was unsteady and lacked insight into his safety, and it identified the potential for injury. He was noted to be chair bound and needing supervision to walk with a frame. The assessment recorded: '[C]an be up 10 times a night — Settles best with help of: medication but usually wanders, unsettled.'

**Medication error**

20. At the time of his admission to the care home, Mr A's GP (Dr D) had prescribed oxycodone CR[12] 80mg twice daily and OxyNorm[13] 40mg 2–4 hourly if needed for pain. Mr A was prescribed morning and evening medication as follows:

Morning: 80mg oxycodone CR, 2x laxsol,[14] 0.5mg haloperidol,[15] 2x paracetamol,[16] 20mg omeprazole,[17] and 4mg dexamethasone[18]

Evening: 80mg oxycodone CR, 2x laxsol, 0.5mg haloperidol and 2x paracetamol

21. RN E told HDC that the care home uses the electronic medication management system '1CHART', and the GP who provides medical services to the care home residents prescribes using this system. However, while at the care home, Mr A continued to receive medical care from Dr D. As Mr A was a respite resident and he retained the services of his usual GP, he could not be added to the 1CHART system until the pharmacy reopened in the morning on Day 2, and his initial prescribing on Day 1 was completed on a paper medication chart.

22. On the morning of Day 2, Mr A was erroneously administered his evening blister pack medications by senior caregiver Ms F. Mr A's daughter, Ms B, raised concerns that Mr A received an 'overdose of his pain medication (Morphine), and that this resulted [in] him becoming incoherent and falling out of bed'.

23. The error was discovered at around 5pm on Day 2, when staff went to administer the evening medications. Ms B stated that Mr A's wife recognised that the wrong medications were being given. The care home told HDC that the caregiver noted that Mr A's evening medication blister pack for that day was missing, and that his morning medications were still present. As a result of the medication error, Mr A missed his morning dose of omeprazole and dexamethasone.

[11] Relevant dates are referred to as Days 1–9 to protect privacy.
[12] Oxycodone is an opioid medication used for treatment of moderate to severe pain. Oxycodone CR is a controlled-release preparation taken 12 hourly.
[13] OxyNorm is an immediate-release oxycodone preparation.
[14] Medication used to prevent constipation.
[15] An antipsychotic medication.
[16] Medication used for treatment of mild to moderate pain.
[17] Medication to treat frequent heartburn.
[18] A corticosteroid anti-inflammatory medication.

24. Controlled medication was not contained in the blister packs, and Mr A received the correct dose of controlled (pain relief) medication. The care home's Medication Administration procedure requires that controlled medications (such as oxycodone) are kept in a locked cupboard in a locked room and signed out for administration by two staff as required. This medication process is in line with Ministry of Health Medicines Care Guides for Residential Aged Care. The controlled drug register entries provided to HDC by the care home show that two staff signed out the oxycodone, which followed the Medication Administration procedure.

*Actions taken*

25. The Medication Administration Procedures require mandatory reporting of medication discrepancies on a Medication Error Notification Form or Adverse Event Form, and for medication discrepancies to be reported to the on-duty person in charge (the Clinical Charge Nurse, Nurse Manager, or a registered nurse) immediately. On becoming aware of a medication error, the most senior person on duty will contact the doctor and state the details of what has occurred.

26. Once the error was discovered, the caregiver completed an adverse event form and reported it to both RN E and RN D. The medication error is also noted on the Nursing/Care Progress notes by the afternoon shift registered nurse. Mr A was given all his usual evening medications along with the missed dose of omeprazole; however, the dexamethasone was withheld as per senior nursing staff advice, as it could hinder sleep. The clinical record does not document whether Mr A experienced adverse effects as a result of the medication error. RN E told HDC that '[Mr A] had no injuries and nil adverse reaction [following the] medication error'.

27. Ms B told HDC that family were informed of the medication error by RN H on Day 2. However, it is unclear whether Mr A's usual GP was informed. RN E told HDC that she recollects informing GP Dr D about the error the following day, although this is not documented in the clinical notes. On Day 3, Dr D documented a call with RN E to discuss Mr A being confused and unsettled at night, but the note does not mention a discussion about the previous morning's omeprazole and dexamethasone medications having been missed.

28. Ms F later completed a reflection form for the medication error that was made on Day 2. On the form, she reflected that she had not followed the '5 Rights' of medication administration,[19] as she was distracted at the time and did not check the label of the pack with the medication chart.

29. RN E told HDC that she considers that the use of a paper medication chart was a contributing factor to the medication error. She stated that the care home now uses their GP for respite patients as well as long-term residents so that new admissions can be set up on the electronic 1CHART medication system promptly.

[19] Right person, right medication, right dose, right time, and right route.

**Pain management and sedation**

30. A detailed pain assessment was completed by RN E on Day 2. On Day 4, Mr A was referred to the palliative nursing team for a review of his increased pain, and his GP reviewed his medications later that day.

*Palliative care review*

31. The Palliative Aged Residential Care Clinical Nurse Specialist (CNS) visited Mr A at the care home on Day 4 while he was being assisted with lunch. The CNS documented in the Nursing/Care Progress notes:

> '[Mr A's] confusion has been ongoing at home and noted to be worse with increased dose of oxycodone. Noted to be currently on oxycodone 80mg BD and oxynorm 40mg PO for breakthrough requiring 1–2 doses/24 hours.'

32. The CNS documented the following discussion with Mr A's daughter, Ms C:

> '[Mr A] is very frail [and Ms C] has noticed a deterioration in a week — although [Mr A] had a better night last night with the increased haloperidol.
>
> Plan — [Mr A] is becoming increasingly frail his confusion is not new — exacerbated by admission here …'

33. The CNS also documented in the clinical notes:

> 'Watch effect of haloperidol over the weekend — if becomes more unsettled at night — consider clonazepam drops — need to discuss with his wife first as became very sedated at home with clonazepam — maybe dose related — has a very long half-life.'

*Medical review*

34. Following the Palliative Care review, Mr A was seen by Dr D at the care home on Day 4. Nursing progress notes state that family were present during the GP visit. Dr D documented:

> 'More confused over the last week, wandering at night — not agitated. Better night last night with increased haloperidol. PO [per oral] intake decreased, c/- [complaint of] shoulder pain.
>
> O/E [on examination] drowsy, mouth dry, skin turgor (decreased), afeb[rile].
>
> A) [Assessment] dehydrated, disease progressing.
>
> P) [Plan] Push PO [per oral intake], at family's request try [decreased] mane oxycodone for confusion; prn haloperidol for confusion nocte; prn clonazepam. NB previous sedation => trial 2 drops only.'

35. Medication changes made by Dr D on Day 4 included:

- Reducing Mr A's oxycodone CR dose to 60mg in the morning and 80mg at night and continuing OxyNorm 40mg, 2 hourly as required with a maximum of 10 doses in any 24 hours.

- Increasing Mr A's haloperidol 500mcg to 1 tablet in the morning, 2 tablets at night and 1 tablet prn (as required) with a maximum of 1 prn dose in any 24 hours.
- Commencing clonazepam 2 drops as required with a maximum of 2 doses in any 24 hours, Indication: agitation/anxiety.

36. Ms B raised concerns that Mr A was sedated. However, RN D told HDC that her understanding was that Mr A was not administered the maximum dosage of oxycodone prescribed for him by his GP. Mr A's PRN Medication Usage Report provided to HDC shows that Dr D's prescribing limits for prn doses of haloperidol and clonazepam were not exceeded during Mr A's admission.

37. RN G told HDC that despite medication changes, Mr A 'remained unsettled especially in the afternoon and at night which made the turning schedule and relieving pressure on his bottom ineffective'.

**Pressure injury management**

38. Prior to his admission to the care home, Mr A's sacral area was noted to be intact by a district nurse, and there is no subsequent documentation in the district nursing/palliative care notes about Mr A's sacral skin integrity. Ms B told HDC that from their experience of 'dressing him every day with [the district nurse] and the lady who came in to shower/bath him at home … he did not go into the Retirement Village with a sacral wound'. Ms B raised concerns that the care home's clinical record incorrectly documents that Mr A had a stage 2 pressure injury when he was admitted to the facility, and raised her concern that the clinical record was altered after family asked to see it.

39. The care home told HDC that a senior caregiver observed that Mr A had a sacral pressure injury on Day 1 and reported the wound to the registered nurse. RN J documented a stage two[20] pressure injury on the adverse event form, and Mr A's family were informed. RN J also instructed senior caregiver Ms F to complete the wound care, and a short-term care plan was started on Day 1. Ms F told HDC that on Day 1 Mr A's '[s]acrum look[ed] red and [she] noticed [an] open area approx. 3 cm in diameter — neither sloughy nor infected [— and the area was] [c]leaned and covered with [a] mepilex border'.

40. The Short Term Care Plan documented that Mr A was to 'turn every 2–3 hour[s] if [he] stay[ed] in bed'. Ms F told HDC that she handed over that a turning schedule had started, although there is no documentation of a formal turning schedule being implemented. The Short Term Care Plan Log was not evaluated during Mr A's week-long admission, and the plan was closed off on Day 9 after Mr A had been discharged.

41. A wound application dressing record was commenced on Day 1. RN D told HDC that her expectation is that a photograph should be taken of pressure injuries when first discovered,

[20] Stage 2 pressure injuries are characterised by partial-thickness skin loss into, but no deeper than, the dermis.

although a photograph of Mr A's sacral pressure injury was not taken until some days later.[21] RN E commenced a full wound assessment treatment and evaluation plan, which included preventative skin care, on Day 2 when she finalised the admission review. The plan was to cleanse the area with Prontosan wound cleaner and apply Cavilon to surrounding skin, and for Mepilex border dressings to be changed every three to five days.[22]

42. RN D told HDC that the respite care checklist does not require completion of a Braden Scale.[23] Regardless, a Pressure Injury Risk Assessment Tool (Braden Scale) assessment was completed for Mr A on Day 2 due to his general health status on arrival at the care home. The assessment noted: '[Mr A] currently has a pressure area on his sacrum.' The assessment documented that Mr A had adequate nutrition and no limitation to his mobility, and that he was able to relieve his own pressure by movement. The score risk indicated that Mr A was 'generally not at risk' of a pressure injury.

43. On Day 2 Mr A's sacral dressing detached in the afternoon, and the sacral pressure injury was noted by the caregiver assisting him into bed. The caregiver informed the registered nurse on duty, RN H. RN H had not reviewed the wound care documentation prior to redressing the wound and contacting one of Mr A's daughters.

44. Ms B told HDC that at 9.28pm on the evening of Day 2, Mr A's 'other daughter [Ms C] was contacted by "[RN H]" at the care home and advised of a "tiny spot" that was the size of a "pin head" on [Mr A's] sacrum'. The resident report does not document how RN H described the pressure injury to Ms C. The wound size and description were not noted by RN H on the wound dressing application record.

45. Mr A's progress notes confirm that his daughter (Ms C) was contacted on Day 2. The registered nurse documented in the resident report:

> 'When carers put him to bed they noted a sacral pressure area. I cleaned and dressed it but it needs to be reviewed tomorrow. I placed him on his side to relieve pressure but not sure he will remain in that position … I spoke to daughter as I thought not to get wife anxious. She said that [they] knew about it and [the district nurse] had been dressing it, but they thought it had healed.'

46. RN D noted that usually the physiotherapist would not be involved in assessments of residents admitted for respite care, but physiotherapy pressure prevention expertise was sought for Mr A due to his condition on admission. The physiotherapist assessed Mr A as having a high falls risk and high pressure area risk on Day 3. She completed a Mobility Support Guide identifying a static pressure-relieving mattress as a support device and advising that Mr A required assisted turns at night for the sacral pressure injury.

[21] The photograph is undated. RN D told HDC that the photograph was taken two days after the pressure injury was discovered (ie, the photograph was taken on Day 3); however, the sacral wound timeline provided to HDC notes that the photograph was taken on Day 7.
[22] Mepilex dressings are designed to stay in place for several days to reduce disturbance of healing tissue.
[23] The Braden Scale is a standardised, evidence-based assessment tool commonly used in health care to screen and document a patient's risk of developing pressure injuries.

47. Mr A's pressure injury was next cleaned and dressed by RN G on Day 4, at which time the area was described on the wound evaluation form as:

> 'Ongoing pressure injury grade II [2] est[imate] 2cm x 3cm in size, sloughy with some visible necrotic tissue. Cleaned with protosan and to continue mepilex border due to moderate exudate.'

48. The plan was for the wound to be reviewed in three days' time.

49. In the afternoon of Day 4, Mr A was seen by the Palliative Care CNS and Dr D. Neither clinician documented in the progress notes that they were informed of any concerns about Mr A's skin integrity.

50. On Day 7, a caregiver documented in the resident report that the dressing was changed. The wound dressing application record notes: '[W]ound: sloughy; skin condition: inflamed; and wound exudate: medium.' RN D told HDC that the pressure injury was photographed at the dressing change on Day 7. The photograph is titled 'Pressure Injury (Grade 2) in Sacral Area' but the document is not dated.

51. The resident report documents that Mr A's pressure injury was redressed on Day 8 prior to his discharge that day, although no entry was made on the wound dressing application record.

52. Ms F told HDC that the second time she changed Mr A's dressing was when a caregiver asked her to reapply the dressing after it had come off during a shower on the day of his discharge. Ms F said that when she changed the dressing, she was 'astound[ed], the wound appear[ed] necrotic and sloughy', and she 'presumed that [her] superior was aware of the condition of the wound'. It appears that the pressure injury was not restaged formally[24] and was not reported to HealthCert during Mr A's time at the care home.

53. After returning home, the district nurse visited Mr A on Day 9. At this visit, the record noted that Mr A had deteriorated, 'seem[ed] over sedated' and had a dark stage three pressure injury on his sacrum. Ms B told HDC that the family believe that Mr A left the facility with a grade 3 pressure injury because he was not monitored or moved frequently and was sedated and left for long periods in a recliner chair with a grade 3 pressure injury.

54. The resident report records that Mr A slept in his bed for the first night at the care home. Overnight on Day 2, he was unsettled and fell twice during the night, and was wheeled into the living room on a recliner chair at 4.45am. While Mr A did spend some nights sleeping in bed, the progress notes document that usually he would spend part of the night in the recliner in the lounge if he was sleepless and needed supervision. Noting that Mr A was a

[24] The care home noted the pressure injury as stage 2 on the initial assessment and on the wound evaluation form completed on Day 4. There is no place on the Wound Dressing Application Record to note any changes to the pressure injury stage.

high falls risk, the Falls Corrective Action Form documents that 'after cares he [was to be] immediately placed [in] the lounge for close monitoring'.

55. RN D told HDC that on admission Mr A was self-mobile and able to relieve pressure. She referred to the nursing progress notes (and behaviour monitoring chart), which show that Mr A was unsettled and walking at times and did not tolerate lying in bed for long. RN D told HDC that the nursing preference would have been for Mr A to spend the majority of his time lying on his side in bed rather than sitting. The type of recliner chair used by Mr A was a medical grade hospital chair, with a pressure-relieving Roho[25] cushion.

**Fluid intake monitoring**

56. An admission nutritional assessment and dietary profile were completed by RN E on Day 2. Mr A's nutritional needs were assessed as a diabetic soft diet supplemented with Diasip.[26] He required prompting to drink, and he was noted to have little appetite and to need prompting and sometimes assistance with eating. This contrasts with the Health Status and clinical risk form commenced by a caregiver on Day 1 and signed by the registered nurse on Day 7. This form notes that Mr A had no problems with eating and needed no assistance with feeding.

57. On admission, Mr A's Nutritional Assessment identified him as being at risk of dehydration as he had been consuming less than a litre of fluid a day. His recent weight loss was acknowledged, along with the risk of malnutrition due to his special diet, and increased need for protein due to poor skin integrity. A High Protein Energy diet for weight management was recommended, with smoothies for afternoon tea, and fluids were to be encouraged.

58. On Day 4, a caregiver documented that Mr A had oral thrush and the registered nurse was informed, and that Mr A was awaiting a GP visit. When Dr D visited that afternoon, he documented in the nursing progress notes that Mr A was '[d]ehydrated, disease progressing', and advised to 'push PO [per oral intake]'. No alternative forms of fluid (intravenous or subcutaneous) were prescribed. There is no mention of oral thrush in the documentation of the GP visit, and no indication that this was brought to his attention. A mouth swab was taken on Day 7 with the results sent to the GP, and Mr A's GP prescribed him treatment for oral thrush on Day 9.

59. A fluid balance chart was commenced at 6pm after the GP visit on Day 4. The chart shows that fluids were offered to Mr A at regular intervals throughout the day, and that small amounts were being taken. The fluid balance chart was totalled at the end of the day, showing a daily intake between 550ml and 780ml, which is less that the recommended minimum of 1,000ml/day. The fluid balance chart was ceased on Day 7 at 5pm. There is no documentation of the reason for ceasing the chart prior to Mr A's discharge, and the care home suggested that this was because Mr A was to return home the next day.

60. RN D told HDC that her expectation is that fluid balances should be totalled every 24 hours, and intakes lower than desired should be recorded in the progress notes and reported to

[25] A cushion used to help prevent pressure injury.
[26] A ready-to-drink low glycaemic index nutritional supplement.

the morning nurse for remedial action. However, there is no evidence of further care planning or any consideration by care home staff of other methods of hydration in response to Mr A's low oral fluid intake.

61. RN E told HDC that her experience is that staff encourage fluids and suggest alternative fluids for residents who are not consuming enough fluid, although staff were unable to improve Mr A's oral fluid intake significantly due to his poor physical condition. RN D also noted that Mr A was 'extremely unwell' when he was admitted for respite care, and that because he was unwell, he frequently refused food or fluids.

62. There is no nursing documentation by care home staff about whether Mr A's condition and lack of appetite was discussed with his family or shaped his subsequent care planning. Ms B noted that there were 'numerous occasions' where the Clinical Charge Nurse Manager tried to discuss the government's three-month 'end of life care' funding. Ms B said that the manner of these discussions made her feel 'pushed' or 'pressured' to sign up for Mr A to stay at the facility. However, these discussions are not documented in the clinical record.

**Other concerns**

63. In addition to the above concerns, Ms B raised with HDC the following issues concerning the care provided by the care home.

*Meals*

64. Ms B expressed concern that Mr A did not receive an appropriate soft diet and that he was given 'fish fingers, meatballs and coleslaw for meals which he could not eat, and was not assisted with eating'. Ms B told HDC that family members visited Mr A at the care home regularly to assist him with eating and ensure that he had soft food.

65. The Dietary Profile and Nutritional Assessment completed on Day 2 shows that Mr A was assessed as needing a soft diet and needed prompting and sometimes assistance with eating. While there is also documentation on the Health Status and Clinical Risk form that Mr A did not need assistance eating, the care home told HDC that Mr A was assisted to eat at each mealtime unless Mrs A was present and wished to assist her husband. The care home believes that the meals were consistent with Mr A's dietary profile, although no documentation of the meals offered and amounts eaten by Mr A has been provided to HDC.

*Monitoring*

66. Ms B told HDC that family visited regularly in three-hour blocks. She is concerned that no one came to check on Mr A while family were visiting, and there are significant documentation gaps in Mr A's behaviour monitoring chart.

67. The care home told HDC that a 24-hour behavioural monitoring form is usual practice for new admissions. However, as Mr A had experienced mild delusions and hallucinations at home and remained unsettled at the care home, the form was continued to identify cues for unsettled behaviour, and to inform a behavioural assessment plan if necessary.

68. The care home also noted that residents are commonly not monitored while family are with the resident and are able to seek assistance from staff if there are any concerns. The care home acknowledged that there are documentation gaps in Mr A's behavioural monitoring chart and told HDC that the monitoring form is an assessment tool to describe behaviours that are over and above the continual and ongoing visual assessments.

*Call-bell response*

69. Ms B raised concerns that when family rang the call bell for staff to assist Mr A to the toilet, no one arrived for 15 minutes, and family had to assist him themselves.

70. The care home told HDC that staff aim to respond to call bells within a five-minute time frame, although it acknowledged that there may be delays during busier periods when staff are involved in the direct care of other residents. The care home reported that the call point activation for Mr A's room indicates that the longest response time was 16 minutes and 35 seconds, and the call response time during Mr A's stay was under 5 minutes for 83.4% of the time.

*Personal cares*

71. Ms B also raised concerns that Mr A was not showered, did not have his teeth brushed, and was not shaved, as requested by his family.

72. The care home stated that personal cares were attended to daily, and the progress notes record that Mr A was assisted to wash, toilet and change into night attire, with washing appearing to coincide with changing of continence products. There is documentation that he was shaved on Day 2 and showered twice, on Day 3 and the final day of his week-long admission. The care home noted that additional personal cares may have been given but not documented. Prior to admission, Mr A's Support Level Needs assessment notes that he was receiving personal care assistance with showering twice a week (and his wife was assisting on other days). There is no documentation of any discussion with Mr A's family regarding requests for personal cares.

*Supervision of trolleys*

73. Ms B told HDC that medication trolleys were left unlocked in the corridors at the care home. She is concerned that a child was observed to look into an unlocked medication trolley, which she understood contained morphine/opioid medication.

74. The care home's Medication Administration Procedures requires that '[a]t no time are staff permitted to leave medication unattended where other Residents, staff or visitors have access', and the medication trolley is to be kept locked (in a locked room). Regarding the storage of controlled drugs (morphine/opioid medications), these are kept in the locked medication safe, and are not stored on the medication trolley.

75. The Regional General Manager of the care home told HDC that it is standard practice for all registered nurses to secure the medication trolleys when not in use. The care home also noted that there is a similar dressing trolley that is not locked and is used for wounds and dressings, and it assumes that this is the trolley that Ms B saw in the corridor. However, Ms B remains certain that the trolley left unattended in the hallway was a medication trolley.

*Discharge planning*

76. The care home has not provided HDC with any discharge documentation that would have been given to family and community agencies to inform them of Mr A's ongoing care delivery at the end of his respite stay.

**Subsequent events**

77. After a week-long respite admission at the care home, Mr A returned home. He was then admitted to a hospice and passed away a week later.

**Further information**

*The family*

78. Ms B told HDC that the level of care Mr A received in his final days was not what the family expected, and it caused additional distress to an already 'horrific' situation. Ms B said that her father went into the care home able bodied, able to eat dinner, able to walk on a walker, and able to talk coherently. Ms B stated that her father deteriorated rapidly in the facility and was unable to walk, hardly able to speak, and became 'seriously dehydrated', and his hands started to jerk from the drug overdose. She stated: 'I believe that this negligence resulted in my father experiencing unnecessary pain and suffering in his final weeks of life.'

79. The care home's response to HDC was sent to Ms B. She responded:

> 'What I read of [the care home's] responses back in [2022] again are disputed from my and my families end and from the accounts of [the district nurses] who were bathing my father the day before he entered the retirement village where there was no evidence of a sacral wound. We did see [a] drug trolley left unattended in the hall way etc so my original complaints still stand and I have not seen evidence that corrects the statements as yet.'

*Care home*

80. RN D offered an apology for the family's distress regarding the care Mr A received at the care home. She noted that Mr A was very unwell when he was admitted, and the quantity of documentation during his one-week admission reflects the extent to which staff endeavoured to understand and meet his complex needs.

81. At the time of these events, the care home had a vacant Clinical Manager role, and this work was reallocated between the Nurse Manager and Charge Nurse Manager. RN E identified concerns about short staffing, and the impact this had on the nursing workload and the completion of paperwork. RN E told HDC that despite requests for more staff, this was not provided.

82. The care home told HDC that the senior management and clinical staff who were employed at the time of the complaint are no longer employed by the village. In addition, the facility was sold, and the new ownership commenced.

*HealthCert*

83. Aged residential care providers are required to report to HealthCert all pressure injuries at stage 3 and above.[27] HealthCert told HDC that it received no notifications from the care home relevant to Mr A's care.

84. The Certification Audit of the care home in 2020 noted a moderate risk relating to corrective action processes. The report stated:

> 'Explanations were provided about initiatives developed following the analysis of data and examples provided were around falls prevention and pressure injury prevention and management. However, gaps were identified, and it was apparent that there is a lack of detail in quality and risk management meetings to inform how all identified risks associated with service provision, including those for individual residents, are followed through. There was limited evidence in clinical or staff meeting minutes that trends, or required actions, identified in quality and risk management data were being followed up and implemented at the service delivery level.'

85. HealthCert told HDC that in 2021 the 'corrective actions [had] been addressed and closed'.

86. A provisional audit was conducted in anticipation of the proposed sale of the care home. The facility fully attained audit criteria, with the exception of partial attainment in the area of dietitian review of residents with specific dietary needs that are not met by the main menu, and corrective actions were required.

**Responses to provisional opinion**

*MLC 2011 Limited*

87. MLC was given an opportunity to respond to the provisional opinion. It told HDC that while there were 'peripheral aspects of the report that [it] might challenge, these are not such as warrant a dispute of [the] ultimate conclusion'. MLC 2011 Limited accepted the finding that aspects of Mr A's care were in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

88. The provisional report was circulated to former staff who provided information to HDC during the investigation, and they had no further comment to make.

*New owner*

89. The new owner was given an opportunity to respond to the provisional opinion. The new owner highlighted that it took ownership of the care home after the period to which the complaint relates.

[27] Section 31(5) of the HDSS Act 2001 requires providers to notify the Director-General of any health and safety risk to residents, and HealthCert requires aged residential care providers to notify it of pressure injuries at stage 3 and above.
See: https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-under-section-31.

90. The new owner told HDC that it will ensure that HDC's 'recommendations are considered and applied in relation to [the new owner's] policies and procedures which [the care home] transitioned to at the time of transfer of ownership'.

*Ms B*

91. Ms B was given the opportunity to comment on the 'information gathered' section of the provisional opinion. Ms B noted that there are discrepancies in the care home's policy and procedure, and that some of the care home's statements have been accepted by HDC because they are consistent with policy, but no other supporting evidence has been provided. Ms B is certain that the trolley seen unattended in the corridor was a medication trolley and not a wound care trolley.

92. Ms B commented that staff acknowledged that Mr A had a sacral pressure injury yet they continued to place him in a (hospital-grade) recliner chair for extended periods, which presumably was painful for him.

## Opinion: MLC 2011 Limited — breach

### Introduction

93. The care home provides rest-home level and hospital-level care. Mr A was admitted for a period of respite care as his condition was changing and his care needs were increasing.

94. Sadly, Mr A died one week after being discharged. I acknowledge that this was a difficult and upsetting time for the family, and again I offer my condolences for the loss of their much-loved husband and father. During my investigation I noted that the family was very supportive of Mr A during his admission to the care home. They visited regularly, assisted with his meals, and were involved in his care. I note their numerous concerns and disappointment with the care he received in the last weeks of his life.

95. Over Mr A's one-week respite admission there were several departures from the expected standard of his care. I consider that taken as a whole, the combination of the inadequate documentation of Mr A's pressure area and injury management and inadequate fluid intake management amounts to a breach of the Code.

### Medication error management

96. On Day 2, a senior caregiver gave Mr A his evening blister pack in the morning. As a result, Mr A's morning omeprazole dose was not administered until the evening, and he missed his dexamethasone dose that day.

97. The Medication Error Reflection Form completed by the senior caregiver documents that she did not follow the five rights of medication administration as there were distractions, and she did not check the paper medication chart against the label of the blister pack. The caregiver noted that Mr A was a respite resident, and the blister pack was different from the

one that she was used to. The Clinical Charge Nurse noted that if the medication chart had been uploaded to 1Chart sooner (before the pharmacy closed) this could have helped to prevent the incident.

98. The care home told HDC that as an outcome of the error, staff were reminded to adhere to the Medication Administration Policy and improve their documentation of errors and follow-up in the clinical record. Individual staff were also informed of, and reflected on, the error. As the delay in Mr A's medication being loaded onto 1Chart was identified as a contributing factor to the error, the care home now uses its usual GP for respite patients so that medication charting can occur promptly through an established process.

99. I note that Mr A received his prescribed amount of oxycodone on Day 2 and did not receive an incorrect dose of opiate pain relief (as suggested by his family).

100. I asked my in-house aged-care advisor, RN Hilda Johnson-Bogaerts, whether the care home's explanation regarding the medication error was reasonable. She advised:

> 'Oxycodone was managed as a controlled drug and … staff … followed due process when administering the Oxycodone. From [RN E's] explanation it seems that due process was followed when managing the medication error … including the implementation of a change in process to avoid a similar error from reoccurring.'

101. RN Johnson-Bogaerts considered that there was no deviation from accepted practice in terms of the management of the medication error, and she noted that an adverse event form was completed, and remedial actions were taken, including staff reflection on the error. She advised that she accepted RN E's explanation that due process was followed except for documenting that the GP was informed, which was explained to have occurred the next day.

102. The care home's Administration of Medication Procedures requires staff to check medications against the prescription on the Medication Order Chart to ensure that the right medication is given at the right time. I consider that this checking requirement is most important in circumstances where residents may be unable to raise concerns about their medications and rely entirely on staff to prepare the medication correctly. I note that the correct medication checking process was not followed, which resulted in the error with Mr A's omeprazole and dexamethasone being omitted, but I accept the advice that there was no departure from accepted practice in terms of oxycodone administration and the management of the error.

**Pressure injury management**

103. I acknowledge that Ms B is firmly of the view that Mr A did not have a pressure injury when he was admitted to the care home. This is supported by the district nurse progress notes provided to HDC, which do not document the presence of a pressure injury prior to admission to the care home.

104. I also note that multiple care home nursing and caregiving staff have documented that they observed Mr A to have a sacral pressure injury when he was admitted. The pressure injury

was staged, dressed, and documented on the Short-Term Care Plan and Wound Dressing Application Record on the day of his admission. Ms B told HDC that on Day 2, the care home notified Mr A's daughter, Ms C, of a pressure injury on his sacrum.

105. Ms B raised concerns that the clinical record incorrectly documents that Mr A had a stage 2 pressure injury on admission to the care home, and that the clinical record was altered after the family asked to see it.

106. The care home denied any alteration of the clinical record. The care home explained that assessment documentation may be commenced on one shift and completed the following day by different staff, as occurred with Mr A's Initial Assessment/Care Plan on admission. When the pressure injury was discovered on Day 1, the registered nurse did not have sufficient time to complete all the documentation, and the Clinical Charge Nurse would have followed up on this on Day 2 when other assessments were completed.

107. I acknowledge that the family and care facility differ in their accounts of when Mr A first developed a sacral pressure injury. In order to make a factual finding, I must be satisfied that it is more likely than not that the fact at issue occurred. I have considered the evidence carefully. Due to the lack of evidence, I am unable to make a factual finding of when the pressure injury developed. However, I consider that the main issue is the management of Mr A's pressure injury. Regardless of when the injury was first sustained, Mr A was known to have a pressure injury during his time at the care home, and I turn now to the nursing care provided to support his skin integrity during the admission.

108. In her initial review of Mr A's care, RN Johnson-Bogaerts advised:

> '[Mr A] would have had an increased risk for developing pressure injuries due to his deteriorating health status, restlessness, taking strong pain relief medication, historic low fluid intake and incontinence issues.'

109. The Mobility Support Guide completed by the physiotherapist on Day 3 identified Mr A as having a high pressure-injury risk. However, as part of Mr A's admission, RN E completed a Pressure Injury Assessment Tool (Braden Scale) on Day 2 that identified Mr A as being able to make 'major and frequent changes in position without assistance' and his score risk was 20, which indicates that he was 'Generally not a Risk' (of developing a pressure injury). The fact that Mr A 'currently ha[d] a pressure area on his sacrum' was noted on the Braden Scale form.

110. In response to Mr A's identified pressure injury, a Short Term Care Plan was commenced on Day 1 and requested regular turns (if he stayed in bed), even though staff noted that this was difficult to implement. Multiple interventions were put in place to manage the injury, such as a Wound Assessment, Treatment and Evaluation Plan completed on Day 2 and a nutritional assessment and physiotherapy referral completed on that day, and pressure-relieving devices such as a Roho cushion, hospital chair, and a static pressure-relieving mattress were provided, although the date on which these interventions commenced is not documented.

111. After reviewing additional information provided by the care home, RN Johnson-Bogaerts considered that 'there seemed to have been a documentation issue more than a care planning issue'. She noted that a pressure injury risk assessment was completed, and appropriate and holistic interventions were planned and provided. However, she noted deficiencies in documentation that could have improved the communication and care coordination between nursing shifts. She concluded that Mr A's pressure injury management deviated from accepted practice mildly to moderately because of the issue with documentation.

112. Further clinical advice was sought from RN Jane Ferreira, who concurred with the physiotherapist assessment of Day 3 that Mr A was at high risk for pressure injury. She considered that Mr A's care 'met the minimum standard of practice in the circumstances', but that there were 'mild to moderate departures from accepted practice standards, with identified opportunities for improvement in nursing assessment, care planning, communication and documentation standards'.

113. Both nursing clinical advisors noted opportunities where documentation of Mr A's pressure-injury care and interventions could have been improved.

114. RN Johnson-Bogaerts noted:

> 'On [Day 1] … [t]he description of the wound is in line with a stage 2 pressure injury. A stage 2 pressure injury presents itself as an intact or open blister or as a shallow wound with no slough or bruising.'

115. RN Johnson-Bogaerts considered that 'the wound care instruction [dated Day 2] was appropriate for a small stage 2 pressure injury with a dressing frequency of 3 to 5 days'.

116. However, on Day 4 the wound is described as 'sloughy with some visible necrotic tissue'. RN Johnson-Bogaerts noted that the description of the wound on both the Wound Assessment, Treatment and Evaluation Plan and the Wound Dressing Application Record on Day 4 includes the following:

> '[I]ndicates a deterioration of the pressure injury including inflammation and presence of slough. The description of the wound on the Wound Assessment, Treatment and Evaluation Plan now includes the presence of some necrotic tissue. The treatment plan is to change dressing in 3 days.
>
> I am concerned that at this stage the treatment plan was not reviewed to include a ramping up of pressure relief interventions. It is good practice to include pictures of the wound when documenting pressure injury changes.'

117. The pressure injury was dressed five times and photographed once during Mr A's week-long admission. Photographs of the wound to assist with reviewing the pressure injury were not taken on discovery and on review, and the wound size and description and stage was not documented on the wound dressing application record consistently.

118. The presence of slough and necrotic tissue at the dressing change on Day 4 suggests that the pressure injury plan needed to be reviewed. RN Johnson-Bogaerts advised:

> 'Anytime a pressure injury is seen by the RN during the provision of care is a time to review what stage of pressure injury it is and if something has changed, if the measures in place (wound care and pressure relief) are effective and if escalation is needed to a wound care specialist or GP. This is to be documented in the clinical notes — usually a wound care plan or a short term care plan relating to pressure injury — or similar type of document.
>
> It is also good practice to write in the progress notes about the change and refer to the care plan for details so that the incoming RN knows about the change. When necrosis or slough is being noticed such [a] wound would be at least a level 3 or an unstageable PI and needs to be reviewed by a RN with expertise or a GP. There is a duty to report the PI under section 31 to [Health New Zealand|Te Whatu Ora] and to the Portfolio Manager of the local DHB (or equivalent).'

119. The pressure injury was re-dressed on Day 7 and Day 8. I note that in her statement to HDC, senior caregiver Ms F was asked by a caregiver to change Mr A's dressing on his discharge day (Day 8). Ms F said that she was 'astound[ed]' by the change when she redressed the pressure injury, and 'presumed that [her] superior was aware of the condition of the wound'. The dressing change on the day of discharge is documented in the resident report completed by the caregiver, but the condition of the pressure injury is not documented in the resident report, Wound Dressing Application Record, or Evaluation sheet.[28]

120. I accept that Mr A's pressure injury was assessed as a stage three injury when it was evaluated by the district nursing staff on Day 9 following his discharge from the care home. RN Ferreira noted that while the change in the pressure injury was documented on Day 4, there is no discussion of wound presentation or evidence of a revised approach to pressure-relieving strategies or pain management, and there does not appear to be a revised entry made to the short-term care plan to discuss wound decline.

121. Further, RN Ferreira considers that it is unclear whether concerns were escalated to the clinical lead nurse at the time regarding wound care and interventions, or what information was handed over to the incoming shift for implementation. RN Ferreira also noted that '[i]t does not appear that Mr A's GP was informed or a referral made to a Wound Nurse Specialist for formal assessment, staging and care guidance at this time, which would be accepted practice for a declining wound', and Ms F told HDC that she noted wound decline at the dressing change on Day 8 but 'there is no evidence of clinical review or oversight by a senior nurse within the care record'.

122. While RN Ferreira considered that there is evidence of nursing assessments and healthcare team collaboration present in the documentation, she identified several opportunities to improve the communication and coordination between the people involved in Mr A's care.

[28] The Wound Dressing Application Record and the Evaluation sheet states: 'Complete for each wound dressing application.'

This included supporting documentation about wound assessment, treatment, and evaluation in the nursing notes; revision of care plans and implementation of holistic strategies in response to a decline in Mr A's pressure injury; and communication of concerns between shifts and other members of the healthcare team, ie, senior nursing/GP/palliative care/wound nurse specialist input.

123. I accept RN Ferriera's advice regarding the failure to escalate concerns about Mr A's pressure injury and communication between members of the healthcare team.

124. Caregivers were at times asked to re-dress Mr A's pressure injury. The care home told HDC that on Day 1 RN J asked Ms F to 'complete appropriate wound care' for Mr A. On Day 7 a caregiver documented a pressure injury dressing change, and Ms F told HDC that on 'the discharge day of [Mr A]' (Day 8) she was asked by a caregiver to reapply the sacral dressing. On Day 8, RN J documented in the resident report that a 'mepilex border [was] placed on [the] pressure injury on [Mr A's] sacrum', although the care home told HDC that '[RN J] did not personally carry out the wound care'.

125. The Nursing Council guideline on the delegation of care by a registered nurse to a healthcare assistant (2011)[29] states:

> 'The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation.'

126. I consider that this guideline applies to all registered nurses.

127. Mr A had changing needs, and RN G documented that the pressure injury had 'slough with some visible necrotic tissue' on Day 4. My advisor, RN Johnson Bogaerts, noted that this indicated a deterioration in the pressure injury (see paragraph 116). In my view, with reference to the Nursing Council guideline regarding delegation of care (above), and in the circumstances of a documented deterioration in Mr A's pressure injury, it would have been preferable for a registered nurse to have been directly involved in the assessment and evaluation of Mr A's pressure injury at subsequent dressing changes.

128. Furthermore, the care home's Wound and Skin Care Management Policy notes that wound and skin treatments must be documented to track patterns, trends, and healing times. The policy states:

> 'Regular review of the areas must also be noted detailing deterioration or progress. If healing is prolonged or signs of infection are present, the resident's medical practitioner must be consulted to review the wound and advise on further treatment …

[29] Nursing Council of New Zealand. See: https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx.

> If in doubt as to the severity of an acute injury, have the Registered Nurse request a House Call from the Doctor to assess the injury.
>
> Where wound healing is not optimal, further advice can be sought from external wound care specialists i.e. Hospital Wound Care Specialist.'

129. The resident report documents that Mr A's sacral dressing was reapplied on Day 7 and Day 8, but the wound dressing application record was not completed on Day 8 and there is no documentation describing the condition of the injury. While Ms F recollected that the pressure injury appeared 'necrotic and slightly sloughy', she 'presumed that [her] superiors were aware of the condition of the wound'. There is no record that Ms F reported her concerns about Mr A's pressure injury to the registered nursing staff.

130. I note that Mr A's dressing change on Day 8 was not undertaken or supervised by a registered nurse who could provide ongoing monitoring and evaluation of the outcomes of care, and act on any concerns. I further note that the caregivers who were involved in dressing changes did not document that they reported concerns about the condition of the pressure injury to registered nursing staff even when a significant deterioration was observed.

131. As part of discharge planning for Mr A, Dr D documented having received a telephone call from the care home on Day 7 advising that Mr A was returning home from respite care on Day 8 and asking for reactivation of community supports. However, as discussed above, there is no evidence that Dr D was informed that Mr A had developed a pressure injury and required regular dressings. Furthermore, there is no documentation that the care home gave a handover to community care providers regarding the size and condition of the pressure injury so that it could be monitored for signs of comparative improvement or deterioration.

132. Regarding discharge documentation from the care home, RN Ferreira advised:

> 'I note there is no entry in progress notes regarding discharge planning or proposed coordination of [Mr A's] future care needs.
>
> …
>
> Accepted practice would be completion of a nursing discharge form at the end of the respite stay to inform ongoing care delivery. A copy of the form and any additional information would be shared with the resident or their nominated representative, the GP practice, and allied health teams, and in this case include the referral for specialist wound nurse input.'

133. RN Ferreira also noted that there was limited documentation about family being informed of Mr A's changing condition and discharge plan.

134. RN E acknowledged that different pressure area interventions were recorded on different documents, and ideally a clear and comprehensive plan should be documented in the Short

Term Care Plan and progress notes. RN E and RN D also acknowledged that the pressure injury should have been photographed when it was discovered. They said that since Mr A's admission, several changes regarding documentation and staff training have been instituted.

135. I accept the advice from my advisors. In my view, Mr A's pressure injury management should have been reviewed and, when deterioration was noted, escalation to the registered nurse, GP or wound nurse specialist should have been considered. I also consider that Mr A's family should have been kept updated with changes in his condition, particularly as he was admitted for respite care and he would require continuing care and pressure injury management after he returned home.

136. In addition, I am critical that different pressure area interventions were recorded in different documents, and that the pressure injury was not photographed when it was discovered. Clinical records should provide clear communication of resident care needs across nursing shifts and staff changes, and they provide evidence of the quality of care planning and interventions delivered. Some information about Mr A's care may have been handed over verbally between shifts and documented on the shift handover sheet, but this did not form part of the permanent clinical record and care plan. While I recognise that on occasion care may be given but not documented, the expectation is that documentation will be timely and completed to an appropriate standard.

137. Both my advisors expressed concerns that documentation of Mr A's pressure injury management deviated from accepted standards, and I accept their advice. In my view, Mr A's pressure injury management should have been supported by adequate and appropriate documentation.

**Fluid intake monitoring**

138. Documentation from the care home shows that on admission Mr A was identified as having a low fluid intake and a risk of dehydration. Despite this, a fluid balance chart was not commenced until Day 4 after Mr A was reviewed by the GP.

139. The fluid balance chart shows that Mr A's fluid intake during his admission was under 800ml each day, and I note that monitoring of his intake was discontinued on the day before discharge, with no rationale provided. RN Johnson-Bogaerts noted that Mr A's daily fluid intake from Day 4–Day 7 was 'concerningly low', and less than the minimum of 1000ml a day. Documentation on the fluid balance chart shows that Mr A was offered drinks regularly. However, RN Johnson-Bogaerts noted: 'It is clear however that the amount he was drinking was not sufficient.' She stated that in such situations, alternative ways can be considered to maintain hydration, such as offering ice cream, soups, ice blocks or yoghurt.

140. RN D told HDC that her expectation was that staff would complete monitoring charts, document and report low intakes, and record reasons for ceasing charts. She noted that Mr A was severely unwell and frequently refused food and fluid, and staff were unable to improve his intake significantly. RN E told HDC that her experience is that staff encourage

fluids and offer alternative fluids to residents who have a low intake. She also agreed that recording of interventions such as encouraging fluids should have been documented better.

141. RN Johnson-Bogaerts advised:

> 'In the circumstances I consider that [Mr A's] hydration management and monitoring of fluids was a moderate deviation from accepted practice. I have come to that conclusion because … when his fluid intake was seen to be too low the documentation does not show that alternative ways to improve hydration were considered and tried [and because] documentation of monitoring of his fluid intake seemed to have stopped midday [Day 7] with no explanation why and while his fluid intake had continued to be poor.'

142. I accept this advice. In the absence of clinical notes that would indicate to the contrary, I conclude on the balance of probabilities that alternative ways to improve hydration were not considered. While maintaining an adequate oral intake became more challenging due to Mr A's changing condition, I am concerned that supporting Mr A's fluid intake with alternative ways was not considered and tried, and that his fluid intake was not documented from midday on Day 7.

**Conclusion**

143. Throughout Mr A's admission to the care home there were several departures from accepted practice. I was concerned to hear of Mr A's respite experience and the distress this caused him and his family.

144. I note that RN E had taken on additional clinical manager responsibilities and was also working on the floor to cover short-staffed shifts. She noted:

> '[T]he workload was unmanageable and resulted in overdue paperwork and I was concerned that [staff] might not be able to meet the standards that the residents needed. Nevertheless the team did try their best to provide quality care in the circumstances … The Nurse Manager and I made several requests for more nursing staff but additional staffing was not provided.'

145. While I acknowledge the efforts of the staff to provide care and to complete documentation in potentially difficult circumstances, I remain concerned that the actual standard of care delivered fell below expected standards in some respects (as discussed above). The care home had an obligation to provide Mr A with an appropriate standard of care, and it has not established that it took reasonable actions at the time of these events to ensure that it met that obligation.

146. Overall, I consider that there were several issues across Mr A's care, including his pressure-injury care and hydration management and monitoring, which involved multiple staff across the service, for which I consider the care home responsible. While I acknowledge that Mr A was becoming increasingly frail, as evidenced by GP and hospital notes prior to his admission, the care home had a duty of care to provide an appropriate standard of care,

and I do not consider that this standard was met. For the above reasons, I find that the care home failed in its duty and breached Right 4(1)[30] of the Code.

**Other comment**

147. As noted above, Mr A's family raised other issues in relation to the care Mr A received during his week at the care home, including the appropriateness of the meals, personal cares, responses to call-bell activation, and supervision of trolleys.

148. The care home has provided a response to these issues, and I further note that RN Johnson-Bogaerts did not raise concerns about these aspects of care. However, I acknowledge that these issues were concerning and did not align with the family's expectations of care delivery. My in-house aged-care advisor raised the question of whether 'enough nursing hours were rostered to meet the health and personal care needs of all residents at all times as is a requirement by the Aged Residential Care Agreement'.

149. The care home is a certified aged residential care provider, and care and service delivery to aged-care residents (which includes satisfaction with meals, care planning, call-bell responses, and medication practices) is monitored by the Ministry of Health, and facilities are audited against the Health and Disability Services Standards. The care home is audited on a regular basis to ensure that these standards are maintained, and I will provide a copy of this report to HealthCert for its consideration.

150. Mr A's family sought a copy of the clinical record, and gaps in documentation raised concerns for them that personal cares were not delivered, and that Mr A was not monitored as he ought to have been. To avoid concerns that documentation has been altered or there are gaps in care, I encourage the care home to ensure that charts (turning, wound dressing and evaluations, food and fluid intake, etc) are kept current and that all documentation and charting is clearly attributable to the writer, and that the date and author of any amendments are identified clearly when documents are updated.

151. Mr A's family were involved in his care, and better communication from the care home may have helped to address their concerns about various aspects of his care as they arose. As an additional point, I encourage the care home to document its communication with family members about incident notifications, any concerns raised about the care provided, and any discussion about end-of-life care planning or funding.

## Changes made

152. The care home acknowledged deficiencies in its documentation and told HDC that it has made several improvements to communication, including a new system in which important clinical information is flagged for clinical team members when they log in.

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

153. The care home advised that documentation has also been improved, particularly through a progress notes guide, using the SOAPE[31] format for documentation, and training was conducted on the importance of reviewing and completing documentation for every admission (whether permanent or respite). A calendar task list for registered nurses has been created so that Short Term Care Plans are reviewed weekly. There is also a new Admission Notes Guide, and a system of documenting pressure injuries on the handover sheet and not removing this entry until the pressure injury has resolved. Documentation and photographing of wounds were discussed at a nurses meeting and staff have been reminded that photographs of wounds should be taken on admission using a measurement application, and the photographs should be dated.

154. The following staff training has taken place:

- Two nurses attended Wound Society training;
- Pressure assessment training was attended by a staff registered nurse;
- The Clinical Charge Nurse (no longer working at the care home) enrolled in postgraduate clinical assessment;
- Wound cases were presented;
- Palliative training was provided to caregivers;
- Medication training was delivered by the pharmacist, and controlled drug training for medically competent staff was delivered; and
- Staff have been reminded of the importance of fluid monitoring.

## Recommendations

155. I recommend that MLC 2011 Limited provide an apology to Mr A's family for the deficiencies in the care provided to Mr A, as outlined in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

156. The care home now has a new owner. In making these recommendations I note that the new owner told HDC that it 'will ensure the recommendations are considered and applied in relation to [the new owner's] policies and procedures which [the care home] transitioned to at the time of transfer of ownership'. However, I seek an assurance that the policies currently in place at the facility address the issues identified in my report.

157. I recommend that the new owner undertake the following actions and report back to HDC within **three months** of the date of this report:

[31] SOAPE is an acronym (Subjective (what the resident says), Objective (what is observed), Assessment, Plan, Evaluation) for organising healthcare report writing.

a) Provide a reminder to staff to ensure that the medication trolley remains within line of sight during medication rounds, including during administration of medication to residents in their bedrooms, and is locked in the medication room when not in use. Confirmation and evidence that this reminder has been circulated to staff is to be provided to HDC.

b) Confirm that respite care checklists used at this facility now include a Waterlow Scale pressure injury assessment on admission, and provide documentation in support of this.

c) Confirm that wound dressing application records and/or evaluation form templates require wound plans to prompt staff to consider taking a photograph and restaging of pressure injuries at every dressing change and provide a place for staff to write their full name on the form to ensure critical thinking regarding wound assessment is occurring, and to ensure accountability for nursing actions, and report back to HDC on this recommendation (including copies of any new or updated documentation).

d) Review the policy relating to Wound and Skin Care Management to ensure that it includes a section on the identification and management of complex wounds that require oversight from registered nursing staff, and a process for allocating residents with complex wound management to registered staff for evaluation and care planning. Documented evidence of the implementation of this recommendation is to be provided to HDC.

e) Provide education to staff about the importance of documenting communication with family members about incident notifications, any concerns raised about the care provided, and any discussion about end-of-life care planning or funding. Education should also be provided to caregiving staff about when to report concerns about pressure injuries to the registered nursing staff so that an assessment and evaluation can be made and appropriate actions taken. Evidence of the above training (such as meeting minutes, training session attendance records, and/or any written information circulated) is to be provided to HDC.

f) Discuss with clinical and management staff that section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about any health and safety risk to residents or a situation that puts (or could potentially put) the health and safety of people at risk and provide minutes of this discussion to HDC within three months of the date of this report.

158. I recommend that the new owner undertake the following actions and report back to HDC within **six months** of the date of this report:

a) Undertake an audit of all residents who developed pressure injuries (any grade) over the previous six months and compare this to Braden Scale assessments to ascertain how well pressure injury risk is being identified and whether risk mitigation strategies are effective. At the same time, audit the documentation to ensure that pressure injuries have been restaged accurately with treatment plans updated at each dressing change, and that appropriate reporting to the Ministry of Health and Health New Zealand portfolio manager has occurred. The results of the audit are to be provided to HDC. If the audit

does not show 100% compliance with the Braden Scale, provide details of what further changes it can make to address this issue.

b) Undertake an audit of fluid balance charts over the last six months to ascertain whether daily intake totals are documented in the progress notes and reported to the registered nurse on shift. The results of the audit are to be provided to HDC. If the audit does not show 100% compliance with reporting and consideration of appropriate strategies, provide details of what further changes it can make to address this issue.

## Follow-up actions

159. A copy of this report with details identifying the parties removed, except the name of MLC 2011 Limited and the advisors on this case, will be sent to HealthCert and Health New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Hilda Johnson-Bogaerts:

'CLINICAL ADVICE — AGED CARE

**CONSUMER** : [Mr A]

**PROVIDER** : [Care home]

**FILE NUMBER** : C20HDC01432

**DATE** : 21 March 2021

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the care home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Specifically I was asked to advise on the following:

*Whether I consider [Mr A's] pressure wound management to have been reasonable in the circumstances, and why.*

*Whether I consider the explanation regarding the medication error to be reasonable in the circumstances, and why.*

*Whether I consider [Mr A's] fluid balance and monitoring to have been reasonable in the circumstances, and why.*

*Whether the facility's relevant policies/procedures/guidelines were followed in relation to the above three aspects of care.*

**Documents reviewed**

Provider's response dated [2020]

Complaint received from [Ms B]

Clinical documentation including: [DHB] discharge summary dated [2020], [DHB] Support Needs Assessment dated [2020], Initial assessment/care plan on admission, Progress Notes, Medication Chart, Medication Chart Report, Wound Dressing Application Record, Wound Assessment, Treatment and Evaluation Plan, Dietary Profile, Fluid Balance Chart, Picture of pressure injury dated [Day 1].

Administration of Medication Policy

Medication Administration Procedure

Clinical Management policy

**Review of clinical records**

[Mr A] was [in his seventies] when he was admitted to [the care home] for (palliative) respite care on [Day 1] and was discharged back home on [Day 8]. His medical diagnosis included metastatic prostate cancer with widespread bone disease. He also had chronic back pain relating to a spinal cord compression and was prescribed regular pain relief medication including Oxycodone a controlled drug. He was able to mobilise with assistance of one person using a walking frame. He had a history of disturbed sleep patterns getting unsettled at night and getting up frequently including showing wandering behaviour and occasionally experiencing confusion. The progress notes include that a sensor mat was put in place beside his bed to alert staff when he would get up. According to nursing assessment conducted at that time of his admission to [the care home] he came to [the care home] with a stage 2 pressure injury. [Mr A] was assessed as needing a normal diet with a soft consistency and received a daily nutritional supplement drink. He needed some assistance with eating when tired and needed prompting with fluids ensuring he would drink enough. Overall he was able to express his needs. He had a very supportive family who visited regularly and were very involved in his care.

**[Mr A's] pressure wound management**

On [Day 1] a Wound Dressing Application Record was commenced to document wound care provided. The description of the wound is in line with a stage 2 pressure injury. A stage 2 pressure injury presents itself as an intact or open blister or as a shallow wound with no slough or bruising. Next dressing due time was entered as [Day 4].

http://nzwcs.org.nz/images/ppig/stop_pressure_injuryday2015/PI_Staging_Chart_A4.pdf.

A Wound Assessment, Treatment and Evaluation Plan was completed for the management of the sacral pressure injury dated [Day 2]. The wound care instructions were appropriate for a small stage 2 pressure injury with a dressing frequency of 3 to 5 days. The care instructions did not include other interventions for the prevention of deterioration and to support wound healing. Good practice requires a holistic approach to the treatment of pressure injuries including a nutritional assessment and treatment, preventative skincare, pressure relief and movement planning.

I did not find among the provided documentation a completed pressure risk assessment to identify [Mr A's] level of risk. Good practice requires the completion of a pressure injury risk assessment to be completed on the day of admission as for example a Waterlow Assessment. This provides the nurses with an objective risk score allowing appropriate interventions to be implemented as recommended in the Frailty Care Guide of the HQSC.

See page 8 of the Skin/Wounds document:

https://www.hqsc.govt.nz/assets/ARC/PR/Frailty_care_guides/Skin_wounds.pdf

I expect that [Mr A] would have had an increased risk for developing pressure injuries due to his deteriorating health status, restlessness, taking strong pain relief medication, historic low fluid intake and incontinence issues.

On [Day 2] (afternoon) the following progress note entry was made by a carer: *during the cares found a look like skin ulcer on his bottom. RN notified.* The registered nurse entry in the progress notes includes that *it needs to be reviewed tomorrow. I put him on his side to relieve pressure but not sure he will remain in that position … I spoke to daughter … she said she knew and the district nurse had been dressing it, but she thought it had resolved.* It would seem that the carer and the registered nurse on duty that afternoon were not aware of the pressure injury for which a wound care plan was commenced the day before. This points in the direction of an issue with coordination of care between shifts. Good practice includes for a new resident to be introduced during the beginning of a shift to the incoming nurses. Care issues as for example pressure injury prevention, pain management and falls prevention are top of the list of issues to be discussed when introducing a new resident to nurses at the start of their shift.

[Day 3], a carer makes the entry in the progress notes that the dressing on his sacrum is still intact.

[Day 4], the description of the wound on both the Wound Assessment, Treatment and Evaluation Plan and the Wound Dressing Application Record indicates a deterioration of the pressure injury including inflammation and presence of slough. The description of the wound on the Wound Assessment, Treatment and Evaluation Plan now includes the presence of some necrotic tissue. The treatment plan is to change dressing in 3 days.

I am concerned that at this stage the treatment plan was not reviewed to include a ramping up of pressure relief interventions. It is good practice to include pictures of the wound when documenting pressure injury changes. Such a picture was not included in the response. The provider's letter of response includes that [Mr A] was given a RoHo pressure relief cushion for his chair and a pressure relief mattress on his bed. The response did not include when he was provided with pressure relief. I did not find any reference to the implementation of pressure relief equipment or strategies in the wound care plan or other provided clinical documentation.

The following days [Mr A] experienced restlessness and shoulder pain. He receives extra pain relief.

[Day 7] the progress notes include an entry that a new dressing was applied on his sacrum with no further description of pressure relief in place or repositioning plan. Later that day the progress notes include that he experienced pain and agitation. He was given pain relief and stayed in his lazyboy overnight to sleep in.

[Day 8], a new dressing was applied in the morning before he was discharged home.

**Clinical advice:**

I consider [Mr A's] pressure wound management to have been deviating moderately to significantly from accepted practice. I have come to that conclusion because:

— There was no documented comprehensive pressure injury risk assessment the day of his admission.

— There was poor care planning in place for the treatment/prevention of the pressure injury that was present which only focussed on wound care and did not include a reassessment of interventions when his pressure injury deteriorated in a very short period of time.

— There was an issue with the coordination of the wound care between shifts.

— There was poor documentation of interventions, no documentation of the pressure relief equipment in use.

**Whether I consider the explanation regarding the medication error to be reasonable in the circumstances, and why**.

The provider's response includes that a medication error occurred when [Mr A] was given his night time medication on the morning using a prepacked system called blister pack. With this error [Mr A] would have received 80mg of Oxycodone instead of 60mg, and would not have received his Omeprazole tablet. This occurred according to the complaint on the morning of [Day 2].

Because Oxycodone is an opioid analgesic and on the list of controlled drugs, the way it is stored, recorded and administered varies from other medications in a manner that recognises the potential serious effects in the event of an error taking place. This was recognised in the provider's Administration of Medication Policy. The Medication Administration Procedure specifies how the administration of controlled drugs is managed differently.

Because the provider's response did not include a copy of the Medication Signing Sheets or copies of relevant pages from the Controlled Drugs Register I could not review if the administration of [Mr A's] Oxycodone was done in line with the Ministry of Health's Medicines Care Guides for Residential Aged Care and the organisation's procedure. According to the medicines guide p 11, controlled drugs need to be kept in a locked controlled drugs cabinet. All transactions are to be recorded in the Controlled Drugs Register. Administration is to be checked and signed by two staff who have demonstrated competence in medicines management maintaining a running balance. https://www.health.govt.nz/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf

The provider's Medication administration errors policy includes that for every medication error a Medication Notification Form is to be completed and *in the event a resident has wrongly received medication, conduct a set of baseline recordings and contact the pharmacy to seek advice without delay.* And, *On becoming aware of a*

*medication error, the most senior person on duty will contact the Doctor stating full details of what occurred.*

The Ministry of Health's Medicines Care Guides for Residential Aged Care mentioned above refers on p 7–8 to medication errors to the effect of the following: all errors need to be documented on an Incident Form, the RN needs to be notified immediately, the resident or EPOA needs to be informed. The guide recommends a quality improvement approach to medication errors including the need for: analysis of errors, audits of compliance with policy and documentation requirements, the use of findings in future education, the documentation of system improvements, and the reporting of quality and risk activities relating to medication management to the clinical governance of the organisation.

It is not clear from the provider's response how the medication error was managed. In addition, I did not find in the progress notes any reference to a medication error having been made, no base-line recording was documented, no communication with the family, doctor or pharmacist was documented in the progress notes. The provider response did not include a medication error report or the medication signing sheets, record of investigation into the error or quality improvement initiative.

**Clinical advice:**

In the situation that the Oxycodone medication was not managed in line with the requirements of management of controlled drugs this would be seen by my peers as a significant deviation from accepted practice.

It would appear from the provided documentation that the medication error was not followed up as required by the organisation's policy and the Ministry of Health's Medicines Care Guides for Residential Aged Care. If this is the case, this would be seen by my peers as a significant deviation from accepted practice.

**Whether I consider [Mr A's] fluid balance and monitoring to have been reasonable in the circumstances, and why.**

On [Day 1] a Dietary Profile and Nutritional Assessment was completed for [Mr A]. This included that he was to have a soft diet, needed prompting and sometimes assistance with eating. He could drink normal liquids but was at risk for dehydration because he drinks less than 4 cups of (less than 1000ml) fluid a day.

On [Day 4] a fluid balance chart was commenced after [Mr A] had seen the doctor. He had developed an oral thrush and was found to be dehydrated. That day it was documented that he drank a total 700 ml, [Day 5] this was 780ml, and on [Day 6] this was 550 ml. These amounts are concerningly low and less than the minimum of 1000ml a day. On [Day 7], only the fluids taken before midday were documented being in total 550ml. There was no documentation of fluid intake of that afternoon, night or the next morning. I did not find any explanation why the monitoring was discontinued.

While it was documented at the time of his admission that [Mr A] was at risk of dehydration it appears from the clinical documentation that support with fluids was not a focus of care. After [Day 4] and when the fluid balance chart commenced the document shows that nurses offered him drinks regularly. It is clear however that the amount he was drinking was not sufficient. In such situation alternative ways can be considered to maintain hydration as for example offering of ice cream, soups, ice blocks, yoghurt etc. I am concerned that the fluid balance chart indicated that fluid intake was too low and no alternative ways for hydration were tried. In addition, it seems that the nurse on afternoon duty and night duty of [Day 7] had failed to continue the focus on hydration and documentation of fluid intake.

**Clinical advice**

In the circumstances I consider that [Mr A's] hydration management and monitoring of fluids was a moderate deviation from accepted practice. I have come to that conclusion because:

— when his fluid intake was seen to be too low the documentation does not show that alternative ways to improve hydration were considered and tried

— documentation of monitoring of his fluid intake seemed to have stopped midday [Day 7] with no explanation why and while his fluid intake had continued to be poor.

**Whether the facility's relevant policies/procedures/guidelines were followed in relation to the above three aspects of care.**

**Administration of Medication Policy and Medication Administration Procedures.** I reviewed the policy and procedures and have found these to be in line with good practice. The information included in the procedure is comprehensive and a good guide for staff on safe medication management. The procedure includes a chapter dedicated to medication errors.

I note that in the situation that [Mr A's] Oxycodone was not managed as a controlled drug this would mean that staff had not followed the organisation's policy.

The medication error which occurred on [Day 2] was not managed in accordance with this procedure.

**Clinical Management Policy.** I reviewed this policy and have found it to be in line with good practice. The policy refers to the Frailty Care Guides and other evidence based documents for clinical guidance. I note that the policy is mainly focussed on the provision of care for long term care and has little reference to short term and respite care admissions and care planning for these residents. The provider's response did not include a specific procedure for Pressure Injury Prevention, Wound Management or for Nutrition and Hydration. Therefore I could not comment on the question if relevant procedure was adhered to. It is normal practice to have clinical procedures on high risk topics such as these.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
**Aged Care Advisor,** Health and Disability Commissioner

**ADDENDUM 15 May 2022**

HDC received from the provider additional information, documentation and a response to the above provided clinical advice. I was asked to review this information and advise whether the information changes any aspects of my initial advice.

**Additional documentation reviewed**

- Provider's letter of response dated 18 January 2022
- Response from [RN D], [the care home's] Nurse Manager at the time
- Response from [RN E], Charge Nurse at the time

**Additional advice [Mr A's] pressure injury management**
[RN E] explained that the RN on duty on the day of [Mr A's] admission commenced the Short Term Care Plan and Adverse Event log for the pressure injury present at the time. She had however not managed to complete the Wound Assessment and other treatment plans due to time pressure. Clinical Charge Nurse [RN E] explained that she picked up the work the next day and completed further assessments including the Pressure Injury Assessment (Braden Scale). Meanwhile pressure relieving interventions were put in place. [RN E] agreed in her response that good care planning for pressure care is to be holistic and that planned interventions should be documented together in the Short Term Care Plan and care outcomes should be documented in Progress Notes to provide a clearer overview. She explains that different interventions had been recorded in different documents but not brought together. This included a nutritional assessment and a physio assessment.

Considering this new information I conclude that there seemed to have been a documentation issue more than a care planning issue. A pressure injury risk assessment (Braden Scale) was completed the next day, appropriate and holistic interventions were planned and provided however the clinical documentation could have been better to assure care coordination between shifts. It was acknowledged that no photograph was taken of the wound at the time. [RN E] explains that since then the "Documentation issue" was addressed in [a nurses meeting] and included a reminder to take a photograph of a wound as part of the documentation. With this in mind I conclude that in the circumstances [Mr A's] pressure injury management was mildly to moderately deviating from accepted practice — this because of the issue with documentation which might have contributed to the issue with the caregiver the next day seemingly being surprised to find a pressure injury.

I note that [RN E] mentioned in her response that "*workload became unmanageable and resulted in overdue paperwork"* and that she was concerned that "*we might not be able to meet the standard of care the residents needed".* She explained in her response that the Nurse Manager and her *"made several requests for more nursing staff but additional staffing was not provided".* This brings up the question if enough nursing hours were rostered to meet the health and personal care needs of all residents at all times as is a requirement by the Aged Residential Care Agreement.

**Additional advice regarding the medication error**

In the additional information provided it was explained that the Oxycodone (opioid) was managed in line with the requirements of management of controlled drugs. At the time the prescription for the morning dose and evening dose were the same (40 mg) and therefore [Mr A] was given the correct dose. Later that week the evening dose was changed (as per 1Chart prescription).

The provider response included that the medication error was documented on the Adverse Event Form and due process was followed with exception of the documentation in the Progress Notes by the person who found the error, and the documentation of informing the GP which was explained to have occurred the next day. The response from [RN E] includes the remedial action taken including a staff reflection. The contributing factor to the error was identified as having the paper based prescription before his medication prescription was uploaded to the 1chart system. This was because [Mr A] was a respite care resident rather than long term resident. [RN E] explained that following this incident it was decided that the usual process would be used for respite residents as well as the long term care residents from now on.

I conclude that the Oxycodone was managed as a controlled drug and that staff had followed due process when administering the Oxycodone. From [RN E's] explanation it seems that due process was followed when managing the medication error and included the implementation of a change in process to avoid a similar error from reoccurring. Deviation from accepted practice in terms of management of the medication error — nil.

**Further general information** about pressure injury management provided 27 November 2022

Any time a pressure injury is seen by the RN during the provision of care is a time to review what stage of pressure injury it is and if something has changed, if the measures in place (wound care and pressure relief) are effective and if escalation is needed to a wound care specialist or GP. This is to be documented in the clinical notes — usually a wound care plan or a short term care plan relating to pressure injury — or similar type of document.

It is also good practice to write in the progress notes about the change and refer to the care plan for details so that the incoming RN knows about the change. When necrosis or slough is being noticed such wound would be at least a level 3 or an unstageable PI and needs to be reviewed by a RN with expertise or a GP. There is a duty to report the PI under section 31 to [Health New Zealand|Te Whatu Ora] and to the Portfolio Manager of the local DHB (or equivalent) as per:

https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-under-section-31

Staging chart:

http://nzwcs.org.nz/images/ppig/stop_pressure_injuryday2015/PI_Staging_Chart_A4.pdf

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
**Aged Care Advisor**
Health and Disability Commissioner'

## Appendix B: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Jane Ferreira:

'CLINICAL ADVICE — AGED CARE

**CONSUMER** : [Mr A]

**PROVIDER** : [Care home]

**FILE NUMBER** : C20HDC01432

**DATE** : 16 February 2023

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the care home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

**Documents reviewed**

Consumer complaint received from [Ms B]

Provider responses [three] including responses from qualified staff

Clinical documentation including admission nursing assessments, initial care plan, wound management records including wound photos, nursing progress notes and allied health medical records

Organisational policies including Pressure Injury Prevention, Clinical Documentation and Report Writing, Adverse Event Management, Communication and Open Disclosure.

**Complaint**

[Mr A's] daughter has expressed concern regarding the clinical care provided to her father while a short-stay resident at [the care home].

**Review of clinical records**

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

What would be the expected standard of care if further deterioration of the pressure injury was noted?

Would these factors change your view about the significance of the departure in this case?

**Background**

[Mr A] was admitted to [the care home] from his own home on [Day 1] for short-term respite care. According to clinical records his medical history included advanced metastatic prostate cancer with widespread bone disease and he was receiving supportive palliative care. [Mr A] experienced chronic back pain related to a spinal cord compression and shoulder pain, and required regular administration of analgesic medications. Preadmission clinical information discussed a hospital admission in [2020] for Urosepsis and related delirium, with community-based nursing services describing a presentation of mouth ulcers, reducing oral intake, frailty, pain and restlessness, with nocturnal urinary frequency and episodes of incontinence.

[Mr A] had a very supportive family who were actively involved in his care. He was discharged home on [Day 8] for ongoing care under a community health team, and passed away [a week after discharge]. I extend my condolences to [Mr A's] family at this time.

**Management of [Mr A's] pressure injury**

According to file evidence [Mr A] presented on admission with a stage 2 sacral pressure injury. As outlined in the organisation's Pressure Injury Prevention Policy, "*the Registered Nurse will assess all Residents during the admission assessment process, to identify risk factors associated with the possible formation of pressure injuries. Any existing breaks in the Resident's skin will be noted and a plan developed to promote their healing".*

The organisation's Clinical Assessment and Care Planning Guidelines state that "*on the day of (within 24 hours) of admission (including respite or short-term admissions) staff will complete an initial assessment/care plan which will function as the care plan for up to the first 21 days of admission".* Additional nursing assessments for pain, mobility, falls risk, pressure injury risk and dietary and nutrition needs are also required to be completed within 24 hours of admission. The policy also states that a short-term care plan must be instigated for the management and evaluation of acute clinical issues.

According to the submitted evidence [Mr A's] skin integrity was assessed by a registered nurse which identified a stage 2 pressure injury. A protective dressing was applied to his sacral site and supporting Wound Dressing Application Record completed. A short-term care plan was commenced and an incident report completed, in line with organisational policy guidelines. A photograph of the wound was included in the submitted evidence however it does not have a recorded date or wound measurement noted, which would be regarded as appropriate documentation requirements. There is no supporting entry in progress notes to reflect this action, which would be recommended practice.

Staff statements report a delay in completing the Wound Assessment, Treatment and Evaluation Plan and additional nursing documentation due to competing shift priorities. While the outstanding areas were completed by a senior nurse on [Day 2], within policy timeframes, it is unclear how [Mr A's] assessed needs as a new admission were communicated to the incoming shifts from the day of admission to ensure the safe coordination and delivery of his care.

An accepted risk mitigation approach is for the new resident to be introduced to the incoming shift team lead and nursing care team, partnered with a verbal and written handover to inform them of the resident's history and specific care requirements. Short-stay resident admissions can be high risk and require collaborative care coordination to ensure care and safety needs are consistently met. It is unclear if this approach occurred as part of [Mr A's] admission.

The pre-admission Needs Assessment and initial nursing admission assessment indicated [Mr A] required assistance with all activities of daily living, including eating and drinking, personal care needs and safety requirements, particularly when in pain and fatigued. The initial nursing assessment indicated that [Mr A] was able to reposition himself and mobilise with the assistance of one person and a walking frame. A pressure injury risk assessment using the Braden scale was completed on [Day 2], in line with the Pressure Injury Prevention Policy. The assessment produced an outcome score of (20), indicating [Mr A] was at no risk of a pressure injury. However, the physiotherapist assessment, [Day 3], indicated [Mr A] required assistance from 1–2 carers to change position from lying, turning, sitting to standing. The mobility assessment showed he required assisted turns at night due to a sacral pressure injury, and was identified as at high risk for pressure injury. Given [Mr A's] complex medical history, chronic pain, declining health status, history of fluctuating oral intake, skin vulnerability, incontinence, and an existing stage 2 sacral pressure injury, I concur with the physiotherapist's view that [Mr A] presented as a high risk consumer.

Nursing risk assessments are clinical tools that need to be supported by clinical judgement. It is important to utilise a holistic assessment lens and implement both preventative and supportive measures according to the identified risk. As outlined in the Frailty Care Guides, New Zealand Wound Society resources and organisational policy, it is important to consider personalised goals for care, with an aim to promote healing, safety and comfort, and prevent decline.

According to the wound care records, [Mr A's] sacral pressure injury and surrounding skin integrity was assessed three times by clinical staff during his stay at [the care home]; [Day 1], [Day 4] and [Day 7]. The Wound Dressing Application Record does not provide a description of the wound type, location or size. The form shows the site was assessed on [Day 1] with epithelising tissue present and that the surrounding skin appeared moist. Wound bed presentation and signs of exudate is not noted. The Wound Assessment, Treatment and Evaluation Plan reflects an appropriate pressure injury dressing was applied per accepted approaches to wound care management.

The organisation's Clinical Documentation and Report Writing Policy states under Wound/Skin Management — "e*nsure assessment of wound dressings is recorded in the wound dressing schedule at the time of changing a dressing and refer to this document in the progress notes".* There is no discussion of wound assessment, presentation and care in progress notes at this time.

The Wound Dressing Application Record reflects the wound was reviewed on [Day 4] with the assessment form indicating the site had declined. There is no discussion of size, location or measurement to support observed signs of change or deterioration. The site is recorded as "sloughy" with surrounding skin "inflamed", medium wound exudate and a pain score of 3/10. The Wound Assessment, Treatment and Evaluation Plan reflects an evaluation statement discussing wound size of 2cm x 3cm with a presence of "slough and necrotic tissue". An appropriate dressing was applied with guidance to renew the dressing in three days. Progress note entries reflect a dressing change, however there is no discussion of wound presentation nor evidence of a revised approach to pressure-relieving strategies or pain management given the identified decline. There does not appear to be a revised entry made to the short-term care plan to discuss wound decline, or a review of pain management strategies or holistic care interventions. It is unclear if concerns were escalated to the clinical lead nurse at the time regarding wound care, pain management or revised pressure-relieving strategies (such as increased frequency of repositioning, revised seating or application of an alternating air mattress), or what information was handed over to the incoming shift for implementation. It is also unclear if nursing staff recognised that [Mr A] may be approaching end of life and required additional support from his palliative care team.

Nursing documentation discusses equipment use such as a static pressure-relieving mattress and RoHo cushion, however there is limited discussion of other strategies to support comfort and wound healing given [Mr A's] identified needs. A personalised support plan outlining timeframes for skin assessments, repositioning, nutrition, hydration, elimination needs, including a pain management plan, would be considered appropriate nursing practice. I note there are discrepancies in the relationship between nursing forms and contemporaneous entries in resident progress notes relating to nursing assessments, interventions or escalation of care concerns. As outlined in the provider communication this presents an improvement opportunity for [the care home] team.

**What would be the expected standard of care if further deterioration of the pressure injury was noted?**

There is limited written evidence of communication with family/whānau to update them on the wound decline at this time. It does not appear that [Mr A's] GP was informed or a referral made to a Wound Nurse Specialist for formal assessment, staging and care guidance at this time, which would be accepted practice for a declining wound. There is discussion in an RN response of involvement with the palliative care team and a GP visit [Day 4], however from a review of nursing progress and medical notes it does not appear the GP was informed of concerns with [Mr A's] skin integrity at the time of his visit. The GP visit records a review of prescribed medications and that [Mr A]

presented with signs of dehydration. There is evidence of a fluid balance chart in use (with inconsistent entries), but no evidence that a nutritional record was commenced to monitor [Mr A's] oral intake given his history, during his stay at [the care home].

Wound management documents on [Day 7] reflect the wound was reviewed with further observations of slough, inflamed surrounding tissue, medium wound exudate and pain. A statement from a staff member acknowledges wound decline but there is no evidence of clinical review or oversight by a senior nurse within the care record. Wound documentation reflects the site was cleaned and redressed according to the management plan. It is unclear what wound size, depth and presentation was at this time. I note there is no entry in progress notes regarding discharge planning or proposed coordination of [Mr A's] future care needs.

According to progress note entries [Mr A] was discharged home on [Day 8]. It is unclear what handover of information occurred between [the care home], [Mr A's] GP, family/whānau and community healthcare providers regarding his ongoing care requirements. Medical notes reflect that the practice was informed via a phone call from [the care home] advising that [Mr A] was for discharge home and to recommence allied health input. Accepted practice would be completion of a nursing discharge form at the end of the respite stay to inform ongoing care delivery. A copy of the form and any additional information would be shared with the resident or their nominated representative, the GP practice, and allied health teams, and in this case include the referral for specialist wound nurse input.

I note from post-discharge allied health records that [Mr A's] pressure injury was assessed by a District Nurse on [Day 9] as Stage 3. The supporting wound photograph, taken [Day 9], indicates significant decline in wound presentation, possibly in keeping with [Mr A's] reported frail health status. This assessment would meet external reporting requirements for a Section 31 notification to the Ministry of Health. It is unclear from the submitted evidence by the community provider if this report was completed.

**Would these factors change your view about the significance of the departure in this case?**

**Clinical advice**

From the evidence reviewed to respond to the above questions it appears the care provided to [Mr A] met the minimum standard of practice in the circumstances, and I concur with the nurse-expert report submitted by my peer. While there is evidence of nursing assessment on admission and collaboration between health colleagues during [Mr A's] respite stay, there are opportunities for strengthening communication and documentation standards.

All nursing assessments, care plans and interventions are required to be supported by contemporaneous nursing documentation to evidence care delivery, inform care evaluation, or appropriate escalation and reporting of resident needs.

I consider there are mild to moderate departures from accepted practice standards, with identified opportunities for improvement in nursing assessment, care planning, communication and documentation standards.

Jane Ferreira, RN, PGDipHC, MHlth
**Nursing Advisor (Aged Care)**
Health and Disability Commissioner'

## Appendix C: Relevant standards

**Health and Disability Services (Core) Standards NZS 8134.1:2008**[1]

'**Standard 3.3 Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.**

*Criteria* The criteria required to achieve this outcome shall include the organisation ensuring:

3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.

3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

**Standard 3.10 Consumers experience a planned and coordinated transition, exit, discharge or transfer from services.**

*Criteria* The criteria required to achieve this outcome shall include the organisation ensuring:

3.10.1 Service Providers facilitate a planned transition exit, discharge, or transfer in collaboration with the consumer whenever possible and this is documented, communicated and effectively implemented.

3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

**Standard 3.13 A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.**

*Criteria* The criteria required to achieve this outcome shall include the organisation ensuring:

[1] Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) replaced by Ngā Paerewa Health and Disability Services Standard on 28 February 2022 https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf

3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

3.13.3 The personal food preferences of the consumer are met where appropriate.'

**[Care home] Wound and Skin Care Management Policy**

'All wound and skin treatments must be entered on the "Wound and Skin Care Treatment Register" to track patterns, trends and healing times.

…

Regular review of the areas must also be noted detailing deterioration or progress. If healing is prolonged or signs of infection are present, the resident's medical practitioner must be consulted to review the wound and advise on further treatment.

…

Where wound healing is not optimal, further advice can be sought from external wound care specialists i.e.; Hospital Wound Care Specialist.'

**Nursing Council of New Zealand**

The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> '1.10 Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers.
>
> …
>
> 4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.8 Keep clear and accurate records.
>
> …
>
> 4.10 Practice in accordance with professional standards relating to safety and quality health care.'