Oceania Care Company Limited (trading as Gracelands Lifestyle Care and Village)

Registered Nurse, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 14HDC01005)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A (aged 77 years at the time of these events) had a skin condition, mycosis fungoides which is a type of lymphoma that begins as scaly, itchy, patches on the skin, followed by thicker plaques and eventually tumours. Mrs A also had lung cancer.

2. Mrs A required hospital-level rest home care. She took up residence at Gracelands Lifestyle Care and Village (Gracelands) in 2012. Gracelands is owned and operated by Oceania Care Company Ltd (Oceania).

3. From 21 Month3[1] 2014, Mrs A's skin condition was deteriorating and staff noticed blood on her bed linen and sheets and she reported experiencing pain during personal cares. Mrs A was prescribed codeine for pain relief on an as needed (PRN) basis. She required this pain relief from 22 Month3 in addition to her regular paracetamol. Mrs A had a pain care plan but it was not updated in response to her changing condition.

4. On 26 Month3, Mrs A telephoned her daughter, Mrs B, who said her mother reported that she was in a lot of pain. The clinical manager at Gracelands, RN C, spoke to Mrs B and commenced Mrs A on an hourly pain assessment tool. RN C sent a facsimile to Mrs A's GP, Dr D, at the medical centre regarding Mrs A's pain levels. That afternoon, a medical centre nurse responded with an amended pain management plan to give paracetamol four times daily, and codeine every four hours prior to cares.

5. The hourly pain assessment tool was filled in by Gracelands staff approximately hourly between 3 and 8pm on 26 Month3, but was not filled in hourly after that.

6. On 27 Month3, RN J contacted Dr D again with concerns about Mrs A's skin condition and pain levels. Dr D reviewed Mrs A and liaised with the public hospital for Mrs A to be admitted that day. Mrs A was given palliative care in hospital and, sadly, she died.

Findings

7. Mrs A's skin condition was deteriorating from 21 Month3 when she was experiencing pain during her cares and blood on her bed linen. From 22 Month3, Mrs A's pain experience was changing, as she required more PRN codeine and began requesting pain relief for "pain all over". However, Gracelands' staff failed to contact Dr D about either aspect of Mrs A's changing condition prior to 26 Month3. In addition, Gracelands' staff also failed to update Mrs A's pain care plan and document the effectiveness of administered pain relief appropriately. Accordingly, Oceania Care Company Ltd did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Consumers' Rights (the Code).[2]

8. Adverse comment is made that RN C should have been more alert to Mrs A's increased need for PRN codeine from 22 Month3 onwards.

[1] Relevant months are referred to as Months 1-3.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill".

Complaint and investigation

9. The Commissioner received a complaint from Mrs B regarding the care provided to her late mother, Mrs A, at Gracelands Lifestyle Care and Village.

10. An investigation was commenced on 17 June 2015. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by Oceania Care Company Limited (trading as Gracelands Lifestyle Care and Village) in 2014.*
- *The appropriateness of the care provided to Mrs A by RN C in 2014.*

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

12. The parties directly involved in the investigation were:

Mrs B	Complainant
Oceania Care Company Ltd	Provider
RN C	Registered nurse / Clinical manager

13. Information was reviewed from the above parties and from:

Medical centre	
Dr D	General practitioner
Hospice	
District health board	
Dr E	Dermatologist
RN F	Registered nurse
RN G	Registered nurse

14. The following people are also mentioned in this report:

RN H	Registered nurse
Mr I	Business and care manager
RN J	Registered nurse
Ms K	Healthcare assistant
RN L	Registered nurse
RN M	Registered nurse
Dr N	General practitioner
Dr O	General physician

15. In-house clinical advice was obtained from registered nurse (RN) Dawn Carey (**Appendix A**).

Information gathered during investigation

Background

16. Mrs A (aged 77 years at the time of these events) had a skin condition, mycosis fungoides, which was diagnosed in 2012.

17. Mycosis fungoides is the most common form of cutaneous T-cell lymphoma. It generally affects the skin, but may progress to internal organs over time. Mycosis fungoides has an indolent (low-grade) clinical course, which means that it may persist in one stage or over years or sometimes decades, before slowly progressing to the next stage. It begins as scaly, itchy, patches on the skin, followed by thicker plaques and eventually tumours. It is incurable, but most patients experience prolonged periods of disease control. There are a number of treatments for mycosis fungoides including: topical steroids, UVB phototherapy,[3] photochemotherapy, chemotherapy, and localised radiotherapy.

18. Following Mrs A's diagnosis, her general medical condition became complex when she snapped her Achilles tendon. She was assessed as requiring hospital-level rest home care so she took up residence at Gracelands Lifestyle Care and Village (Gracelands). Mrs A was later diagnosed with clinical stage 2A adenocarcinoma of the lung[4] in Month 1 2014 and remained a hospital-level resident at Gracelands until 27 Month3. She died a few days later at the public hospital.

19. Gracelands is owned and operated by Oceania Care Company Ltd (Oceania) and is contracted by the district health board (DHB) to provide rest home and hospital-level care to 92 residents. The Clinical Manager at Gracelands at the time of these events was RN C,[5] and the Business and Care Manager at Gracelands was, and still is, Mr I.

Skin and wound care

20. From 2012, Mrs A was seen for her skin condition by the DHB dermatologist, Dr E.[6] Dr E told HDC that, in view of Mrs A's age and general condition, he considered it unsafe to treat Mrs A with immunosuppressive drugs, but believed localised radiation treatment could be useful for treating her tumours. Mrs A underwent weekly courses of narrowband UVB therapy at the DHB to help reduce scaling on her skin.

21. Mrs A had a chronic ulcerating tumour on her right upper thigh that had been present from around March 2012. There was a wound care plan and management sheet filled in by a Gracelands RN that detailed the initial wound care plan: "Daily dressing –

[3] UVB refers to shortwave ultraviolet (UV) rays. Narrowband UVB is the most common form of phototherapy used to treat skin diseases. "Narrowband" refers to a specific wavelength of UV radiation, 311 to 312 nm.

[4] Cancer that begins in the cells that line the alveoli (tiny sacs within the lungs that allow oxygen and carbon dioxide to move between the lungs and bloodstream). A stage 2A cancer describes a tumour larger than 5cm but less than 7cm wide that has not spread to the nearby lymph nodes, or a small tumour less than 5cm wide that has spread to the nearby lymph nodes.

[5] RN C no longer works at Gracelands.

[6] Dr E also saw Mrs A prior to 2011 for hyperpigmented rash over her trunk and limbs which she had had for many years.

apply cavilon cream[7] around wound margin and outer area to protect skin [specifies types of dressing to use].” Changes to this plan were documented and generally related to the type of dressing used.

22. RN H made a referral to the DHB’s wound care specialist on 22 Month2, requesting a wound assessment for Mrs A. The request for assessment stated: “Has chronic ulcerated (tumour) area on R thigh deteriorated in the last [month] causing discomfort and pain … Entire skin is so thin and fragile with some maceration in different areas.”

23. RN G, a DHB wound care specialist, saw Mrs A the next day. RN G told HDC that Mrs A initially refused to have an assessment and review of the wound on her right upper thigh. However, when RN G explained the purpose of the visit, Mrs A agreed to be examined and have clinical photographs taken. RN H told HDC that no changes were made to Mrs A’s wound care plan as Gracelands’ staff were “applying the right dressing and [they] appeared to be doing the right care”.

24. At this time Mrs A had wound assessment and monitoring forms (WA&MF) that stated: “Frequency of Monitoring: daily” (for the period 2 Month1 to 18 Month3). There is a period of six consecutive days between 2 and 9 Month3 with no entries to indicate the wound was assessed or a change of dressing occurred. There are also no corresponding entries in the progress notes to indicate assessment or change of dressing occurred during that period.

25. Dr E told HDC that he last visited Mrs A on 9 Month3 and had no specific involvement in her skincare regime. However, he “could only comment that it seemed that everything was being done to provide suitable dressings and assist her with her day to day activities and showering etc.”

26. On 15 Month3, healthcare assistant (HCA) Ms K recorded in the progress notes: “Underbreast very red and sore more blisters appearing on back very sensitive to touch when doing cares…no longer able to use brush with shower.”

27. On 16 Month3, Mrs A was seen by her GP, Dr D of the medical centre, for a three-monthly review. Dr D recorded “skin isq [no change]”. There was no change to Mrs A’s wound care plan or medication regime following this review. RN J recorded in the progress notes:

> “Informed daughter [Mrs B] of 3 monthly review by [Dr D]. No changes made, advised [Mrs B] of the Dr’s discussion in regards to skin care, wound care of R thigh and general wellbeing. Daughter happy with update.”

28. A new wound care plan and management sheet and WA&MF was commenced for Mrs A’s thigh wound on 18 Month3 by RN H which states: “Dressing to change every 3 days” and “Frequency of Monitoring: Every 3 days”. While there is no record on these forms of the wound being monitored between 18 and 25 Month3, dressing

[7] A barrier cream.

changes are recorded in the progress notes as having occurred at least every three days during this time.

29. RN H stated:

> "I remember that if [Mrs A's] wound was looking good or improving, with the absence of discharges striking through the dressing, then it got changed as required. This was to prevent the wound bed being disturbed and thus promote and assist with the healing process. The wound care management plan states that it had to be changed every three days unless there was discharge showing, which meant it was changed more frequently."

30. The other open lesions on Mrs A's skin were treated with emulsifying ointment and Locoid cream.[8] RN J recorded in the progress notes on 20 Month3 that Mrs A had many open areas located on various parts of her body and that Dr D had advised not to use Locoid cream on open raw areas. RN J documented that she told Mrs A this, and Mrs A agreed that Locoid cream would not be used for the time being, but emulsifying ointment would still be used.

31. On 21 Month3, Ms K recorded in the progress notes that while Mrs A was having her cares done, she was no longer using a brush in the shower, that she used a flannel less often, and that the shower water pressure was causing pain to her skin lesions. Ms K also noted blood on Mrs A's bed linen, and a strong odour. Another HCA noted there was blood on Mrs A's sheets and clothes on 22 Month3.

32. RN L told HDC that between 20 and 22 Month3, she discussed Mrs A's condition with staff and wrote an entry in the hospital communication diary for 23 Month3 so that the morning staff that day would contact Dr D and the nurse from the hospice for further directions regarding Mrs A's care. RN L said that this entry was ticked off in the diary. However, there is no record that Dr D or the hospice was contacted at that time.

33. On 23 Month3, another HCA recorded in the progress notes that there was "a lot of blood on floor and bed again".

34. RN L worked the afternoon shift on 23 Month3. At that time she redressed Mrs A's upper thigh wound and discussed the wound and Mrs A's care with RN C. RN C told RN L that she would take photos of the wound the following day and RN L documented this.

35. Mrs A's last UVB treatment was on 24 Month3.

36. On the morning of 27 Month3, RNs G and F and a clinical photographer visited Mrs A. RN G recalls discussing with RN J Mrs A's pain relief and the need for continued monitoring of the wound condition. RN G recommended contacting Mrs A's GP and also Dr E for further advice regarding her skin care management.

[8] Hydrocortisone cream used to reduce the swelling, itching, and redness caused by a variety of skin conditions.

37. RN J contacted Dr E on 27 Month3 for advice on dealing with Mrs A's skin condition at that time.

Pain management

38. Mrs A had a "Person Centred Care Plan" (PCCP) which was to be reviewed six monthly or as her needs changed. Regarding pain control, this plan (pain care plan) stated that Mrs A would be monitored for any signs of pain and that "interventions/support" was analgesia as charted. While the date of this care plan is not recorded, the date of review from her earlier care plan would suggest this was updated in early 2014.

39. Mrs A was prescribed codeine phosphate 30mg to be used as needed (PRN) for pain, up to once every four hours. Mrs A was also prescribed paracetamol 500mg (two tablets, twice daily) as a regular medication.

40. Mrs A did not receive any codeine between 16 and 21 Month3. It was recorded that Mrs A experienced pain during cares on 15, 21, and 22 Month3. Thereafter, Mrs A was administered 30mg codeine twice on 22 Month3, twice on 23 Month3, once on 24 Month3, and three times on 25 Month3. However, there is no documentation recording any assessment by staff to evaluate the effectiveness of the PRN codeine on these dates. Mrs A also received paracetamol, as prescribed, every day from 16 to 25 Month3 and an additional 1000mg paracetamol at 12.30pm on 24 Month3.

41. RNs' H and J told HDC that Mrs A was assertive about the care provided to her. RN J said that Mrs A would often refuse her paracetamol stating she was not in pain. It is recorded in the progress notes that on three occasions between 23 and 26 Month3, Mrs A requested pain relief for "pain all over". A senior HCA also told HDC that Mrs A would request any pain relief she required or would ring her bell and inform staff of what she wanted.

26 Month3

42. The progress notes for this day record an entry from Ms K stating: "Cares completed very sensitive and indicating signs of [excruciating] pain when showering…informed [RN M] nebuliser used for comfort, cares decline[d]." RN C then documented: "commenced on hourly pain chart". Neither entry has the time of documentation recorded.

43. Mrs B told HDC that on 26 Month3:

> "I had a call from Mum telling me I needed to go to her straight away, her cares were being ignored and she was in a lot of pain … Mum had never done that before so I was alarmed … but [I] said I'd call the nursing staff to find out what was going on …"

44. Mrs B said that she called Gracelands and spoke to RN M about her mother's condition. Mrs B said RN M told her that Mrs A was on her paracetamol regime and he had just given her codeine which should kick in shortly, but he would get RN C to contact her (Mrs B).

45. Regarding Mrs A's care, RN C stated:

> "As a rule I checked on each patient first thing in the morning and last thing before leaving in the evening to ensure they were ok. My recollection was that [Mrs A] was sleeping comfortably during most of these visits….I next became involved in [Mrs A's] care when alerted by [RN M] that more pain relief was needed."

46. RN C said that as soon as she became aware of Mrs A's pain, she instructed an hourly pain chart. She stated that when pain relief was given to patients, all staff were aware to check them 20 minutes later to ensure it had worked.

47. RN C telephoned Mrs B after checking on Mrs A. Mrs B said that RN C confirmed Mrs A was in a lot of pain, and said that she had commenced an hourly pain assessment tool. Mrs B said RN C told her that she would arrange for the doctor to visit as he would be able to make any referrals to the hospice or the hospital. There is no documentation of the communications between Gracelands' staff and Mrs B on this day.

48. RN C also sent a facsimile to Dr D with the subject "Regular analgesia (paracetamol) and codeine prior to cares". It stated:

> "Pain 8/10 not prescribed enough analgesia had paracetamol which has no effect and codeine is just taking the edge off it. On hourly pain chart starting today."

49. A medical centre nurse responded by facsimile:

> "1545hrs – as [discussed with] [a medical centre nurse], now that [Mrs A] is comfortable at rest plan is to give paracetamol 1gm [four times daily] and to give codeine 30mg [every four hours] prior to cares and increase in [frequency] to get on top of pain. Regards [RN] (as [discussed with] **[**Dr N])"

50. Dr D told HDC that the first communication with Gracelands regarding Mrs A's pain requirements was on 26 Month3. Dr D was not at the medical centre at that time as he works half a day on that day. However, he said that the medical centre practice nurse obtained the information she required from the attending RN at Gracelands, and had a discussion with Dr N (who covers Dr D's patients during that time).

51. It is recorded that Mrs A received codeine at 12.15pm, 5pm and 9pm, and paracetamol at 8am, 5.35pm and 8pm on 26 Month3.

52. The pain assessment tool (for hourly monitoring) was filled in at the following times on 26 Month3: 3pm, 3.20pm, 4.30pm, 5pm, 7.30pm, 8.05pm, and at 2am on 27 Month3. Mrs A's reported pain levels were between 2 and 6 out of 10.

53. RN L worked the night shift on 26-27 Month3 and recalls being told by a HCA that Mrs A had pain. At 2am, RN L documented the assessed pain score of 4/10 on the pain chart and gave Mrs A 30mg codeine. RN L said she encouraged Mrs A to let her know if this did not provide relief or if she had any other concerns. RN L told HDC her intention was not to disturb Mrs A if she was asleep. RN L said that the HCA

reported to her that Mrs A had settled, and this was confirmed when she reviewed the notes at 6.30am at the end of her shift. RN L also verbally reported to registered staff commencing the morning shift that analgesia was given overnight.

54. RN C recalls telephoning the unit overnight and being told that Mrs A was comfortably asleep.

27 Month3

55. On 27 Month3, Mrs A received 30mg codeine at 7.30am along with her prescribed paracetamol.

56. As noted above, that morning RN G visited Mrs A at Gracelands along with RN F and a clinical photographer. RN G recalls discussing with RN J Mrs A's pain relief and the need for continued monitoring of the wound condition. RN F recalls that Mrs A's pain relief and monitoring had been addressed by Gracelands' registered nurses. RN J recorded in the progress notes that "wound nurse [RN G] agrees that skin condition mycosis fungoides is at an acute stage. Symptoms include; pain, bleeding, pus seeping from nodules, cold as skin so thin, Panadol and codeine little [effect]".

57. Mrs B told HDC that she telephoned Gracelands to discuss her mother's condition and spoke to RN J. Mrs B said that at this stage she was desperate to get her mother externally assessed, so she told RN J that she would call the hospice. RN J told HDC that she was about to suggest this as well, for advice on pain management medication. There is no record in the clinical notes of this telephone conversation.

58. Mrs B telephoned the hospice. She said the hospice assured her that anyone could make referrals to them, and said they would send a community nurse out to see Mrs A as soon as possible. RN J recorded in the progress notes that day: "referral has been made to [the hospice] and [Dr D] will contact hospice nurse."

59. RN J told HDC that, given Mrs A had been seen by the GP approximately a week prior to her hospitalisation and there had been no significant changes noted at that review, the need for a change in her plan of care was not pursued until the time of the change in her condition on 27 Month3.

60. That morning, RN J sent a facsimile to Dr D stating:

> "Concerned with [Mrs A] this morning seems quite unwell. She has what appears to be an acute flare up of her mycosis fungoides – many nodules present bleeding and pus present – querying infection and review for antibiotic. Pain is significant this morning can barely move. Please would you pop in and review [Mrs A] for pain relief paracetamol and codeine ineffective temp 36° urine also very concentrate[d] … Would you like me to spend [specimen to] lab. Many thanks [RN J]."

61. After receiving this message, Dr D telephoned RN J. Dr D recalls he said that it sounded as though Mrs A should be admitted to hospital. However, Mrs A did not want to go to hospital, so Dr D visited her at Gracelands around lunchtime.

62. Dr D said that Mrs A's condition was not able to be managed out of hospital. Dr D told HDC he strives in his everyday practice to keep patients at home or managed in their residential placement if they are at the terminal stage of their conditions. However, due to the combination of Mrs A's conditions and the secondary infection, he felt that it was in Mrs A's best interests for her to be admitted to hospital. Dr D noted Mrs A was in "considerable pain" at the time of his visit and her oral medication was not controlling her pain. Therefore he considered she needed "syringe drivers"[9] and the possible help of the pain or palliative care team in hospital.

63. Mrs A remained reluctant to go to hospital. Dr D telephoned Mrs B to explain the reasoning behind the need for Mrs A's admission. He liaised with the hospital to arrange admission. Mrs B persuaded her mother to go to hospital, and arranged for her niece to go to Gracelands and then follow the ambulance to hospital.

64. Dr D stated:

> "Reflecting on my own care during this period, in the future I would consider administering, or prescribing further and stronger pain relief for a patient in this situation, whilst the admission was arranged and whilst waiting for the transportation to arrive."

Transfer to the public hospital

65. Mrs A was transferred to the public hospital by ambulance at around 5.20pm on 27 Month3. She was assessed in the Emergency Department as triage category 4[10] and her presenting complaints were recorded as "painful eczema all over body … pain to all of body, skin flaking and thin, bruising evident in places". The house officer recorded that Mrs A had been feeling acutely unwell for at least four days. Mrs A was commenced on a syringe driver initially with fentanyl.[11]

66. On 28 Month3, general physician Dr O discussed Mrs A's poor prognosis with Mrs B. It is recorded that they discussed that Mrs A's skin loss was extensive and she was at high risk of serious infection and fluid loss. Mrs B recalls Dr O likening Mrs A's condition to that of a burns victim with over 70% of her skin being affected so she was losing fluids through each open ulcer. The plan was to continue treatment with antibiotics and IV fluids and protect Mrs A's skin with creams.

67. Mrs A had input from the palliative care team over the following days. Her syringe driver was changed to provide morphine. She was unable to sleep due to pain, and she experienced shortness of breath. Mrs B explained that her mother experienced diarrhoea and soiled the bed, and her open ulcers were cleaned while she was in bed. She said "the shock of each incident made her so short of breath that at one stage I thought we were going to lose her from not being able to draw breath." Mrs B

[9] A small infusion pump used to gradually administer small amounts of medication to a patient.
[10] New Zealand EDs use the Australasian triage scale which has five triage categories ranging from category 1 for very urgent patients to category 5 for less urgent patients. Category 4 indicates that a patient should be seen within 60 minutes.
[11] A synthetic opiate drug which is a powerful painkiller.

explained that she had to ask for a nebuliser for her mother, "which stabilised her enough for us to see in the morning shift."

68. Mrs A was commenced on the Liverpool Care Pathway for the Dying Patient[12] and died with family present.

69. The cause of death, as stated on the death certificate, was sepsis with the antecedent cause of bacterial infection of the skin and due to the underlying cause of cutaneous T cell lymphoma.

Further information

70. In a concluding statement RN J told HDC:

> "I believe that necessary care was provided, and health professionals external to Gracelands were contacted at the appropriate times … [t]he days, in which a decline was seen, appropriate actions were taken once gaining consent from [Mrs A]. Based on GP visits and external visits from other health professionals [Gracelands'] nurses were not advised to alter current care. The concern in regards to pain relief/management was not because she was not receiving any – she was receiving pain relief around that time of deterioration. However, based on the amount of PRN (as required) pain relief given over the past few days leading up to hospitalisation, and in particular 26 and 27 [Month3] the frequency in which the pain relief was given regularly, both am and pm duties indicated that pain level had increased, and a need for pain relief review was necessary – the GP was informed of this by fax dated [27 Month3]."

71. Mrs B stated that she believes her mother's final days would have been comfortable, "rather than the traumatic experience it was for her and us" if the hospice had been consulted as soon as the deterioration in her condition was noted. Mrs B considered this would have to have been "way before the week she was finally admitted to hospital".

Gracelands' policies

72. Gracelands' 'Person Centred Care Planning Policy' (PCCP), issued May 2010, states:

> "The Person Centred Care Plan is evaluated on a 6 monthly basis or sooner as required when the status of the resident changes. This evaluation is undertaken by the Multidisciplinary Team, the resident and preferably the resident's family/representative (refer Multi-Disciplinary Policy)."

73. Gracelands' 'Pain Management Policy', issued July 2012, states:

> "…[A] resident with pain who is able to participate in the process is assessed by a Registered Nurse using the Oceania approved tools. The onset of the pain, its location, duration, type, aggravating and, relieving factors and treatments already tried are included in the assessment.

[12] A care pathway covering palliative care options for patients in the final days or hours of life. It was developed to help doctors and nurses provide quality end-of-life care.

> …If the pain is severe, or if it is not severe but persists for longer than 48 hours, the doctor is advised and requested to carry out an urgent medical assessment of the resident.
>
> …While an on-going pain management plan is being developed, the short term problem plan is reviewed at least weekly, or more frequently if the resident's condition deteriorates.
>
> The effectiveness of the treatment is evaluated after each dosage or treatment is given. This is to be recorded in the resident's progress notes and the pain monitoring tool."

RN C

74. RN C was the Clinical Manager at Gracelands at the time of these events. She commenced work at Gracelands in December 2013. She told HDC her induction involved a two-day management training course and working alongside a Clinical Manager from another Oceania facility for about a week. She also completed her InterRAI[13] training and syringe driver assessment.

75. RN C told HDC that she provided internal training to staff on assessment of falls and pain tools. She said that she trained 10 carers once a month on all aspects of care, including pain tools and arranged external education for RNs.

76. The Clinical Manager job description (dated October 2008) states:

> "Job Purpose…The key purpose of this role is to provide effective clinical leadership to clinical and care staff, through the development, implementation and evaluation of care plans in accordance with contemporary clinical standards, Oceania Group quality and risk standards as well as achieving funding requirements".

77. The "Clinical Manager/Leader Responsibilities: Guidelines" (issued November 2013) required RN C to do the following:

> "Daily Requirements: …
>
> - Ensure you have personally checked critically unwell residents, and worked through plans of care with RN prior to coming in to give manager handover. Ensure required monitoring is in place and active where indicated: … doctor's input, pain management, contact with family …
>
> Complete in the fo[u]rth week of every month:
>
> - Medication management: … Check usage of PRN medication and organise medication reviews for those residents using PRN medication regularly; Check that staff are writing in the Progress Notes when giving PRN medication and are noting effect".

[13] InterRAI provides systems to enable comprehensive, standardised evaluation of the needs, strengths and preferences of persons receiving rest home care.

78. RN C said that she resigned from Gracelands later in 2014 for personal reasons.

Subsequent events

79. A Health and Disability Services Standards (HDSS) audit of Gracelands was completed by HealthCERT (Ministry of Health) in February 2015. All but two standards assessed were fully attained. The following standard was one of the standards partially attained:

- Evaluation (Consumers' service delivery plans are evaluated in a comprehensive and timely manner) – partially attained because during review of restraint and enabler management safety, it was found that two of three restraint plans were not evaluated within the expected timeframes.

80. Oceania told HDC that "Gracelands Staff and Oceania clinical support staff have identified lapses in our systems since receiving the complaint and embraced the corrective actions necessary to ensure such concerns are not raised again". These corrective actions include:

- Education and training on: documentation and care planning, peer review, mini mental state examinations, delirium toolkit, wound care, diabetes, and subcutaneous fluids.
- Changes to GP service provision.
- Proactive management of poor performing staff.
- Regular facility health checks.
- Regular input from Oceania clinical and quality team.

81. Mr I told HDC that a number of the nurses involved in the direct management of Mrs A have since left Gracelands' employment.

Responses to the provisional opinion

82. Responses to the provisional opinion were received from Oceania and RN C. A response to the "Information gathered" section of the provisional opinion was received from Mrs B.

83. Oceania told HDC that it would ensure that pain management and pain assessment education is provided to all staff on a regular ongoing basis. Oceania stated that it sincerely apologises to Mrs A's family for the circumstance that led to it being found in breach of the Code. RN J provided input into Oceania's response and stated, "I do think this is a lesson for all involved".

84. RN C had no comments to make in response to the provisional opinion.

85. Mrs B considers that there was a lack of communication between Gracelands staff, external providers, and her family. She considers that she should have been informed about changes in her mother's condition, care and treatment. She said that knowing about these changes "would have certainly changed her perspective of [Mrs A's] condition at that time". When information was provided, Mrs B said that she asked

Gracelands staff to contact the hospice. She is concerned that this did not happen and she had to contact the hospice herself.

Opinion: Oceania Care Company Limited (trading as Gracelands Lifestyle Care and Village) - Breach

86. Mrs A was a hospital-level resident at Gracelands from March 2012 until 27 Month3 2014. She suffered from mycosis fungoides, which begins as scaly, itchy, patches on the skin, followed by thicker plaques and eventually tumours. In Month3, Mrs A's condition deteriorated and she was transferred to the public hospital on 27 Month3, where she died a few days later.

87. Oceania Care Company Ltd had a duty to provide Mrs A with services with reasonable care and skill. It also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards[14], which state:

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

Skin Care – Adverse Comment

88. From 2012, Mrs A was seen for her skin condition by Dr E. Mrs A had a number of open lesions on her skin and these were generally treated with emulsifying ointment, Locoid cream and weekly narrowband UVB therapy. Following a referral from Gracelands regarding her skin and wound care, Mrs A was reviewed by a DHB nurse specialist on 23 Month2.

89. On 15 Month3, it was noted by a HCA that Mrs A had more blisters appearing on her back and was sensitive to touch during cares. Mrs A was seen by Dr D for a three-monthly review on 16 Month3, who did not note a change in Mrs A's skin condition. On 20 Month3, RN J recorded that there were many open areas on Mrs A's body and that Dr D had advised not to use Locoid cream on open raw areas.

90. On 21 and 22 Month3 it was recorded that Mrs A experienced pain during cares and on 21 and 22 Month3 staff noted blood on Mrs A's bed linen. On 23 Month3, a HCA noted there was "a lot of blood on the floor and bed again". Mrs A's last UVB treatment was on 24 Month3.

91. My expert advisor, RN Dawn Carey, advised: "[Mrs A's] general skin integrity appears to have deteriorated with noticeable blood loss being reported 22-23 [Month3]. In my opinion, this should have resulted in timely communication with her GP and probable input from a skin specialist."

[14] NZS 8134.1.2: 2008 published by the Ministry of Health.

92. I accept RN Carey's advice. In my view, there were signs that Mrs A's skin condition was deteriorating from 21 Month3 onwards, noting the reports of pain during her cares and blood on her bed linen.

Wound care – Adverse Comment

93. Mrs A also had a chronic ulcerated tumour on her right upper thigh, for which she had a dedicated wound care plan.

94. During the period 2 Month1 to 18 Month3 the WA&MF stated the tumour was to be monitored daily. However, there were no records on either the form or in the clinical notes between 2 and 9 Month3 to indicate the wound was dressed at that time.

95. On 16 Month3, Mrs A was seen by Dr D for her three-monthly review. Dr D was satisfied with the management of Mrs A's wound and her medication regime.

96. On 18 Month3, a new wound care plan and management sheet and WA&MF was commenced by RN H which states: "Dressing to change every 3 days" and "Frequency of Monitoring: Every 3 days". While there is no record on these forms of the wound being monitored between 18 and 25 Month3, dressing changes are recorded in the progress notes as having occurred at least every three days during this time.

97. On 27 Month3, RNs G and F from the DHB reviewed Mrs A's wound. RN G discussed with RN J Mrs A's pain relief and the need for continued monitoring of Mrs A's wound condition. RN G recommended contacting Mrs A's GP and also Dr E for further advice regarding her skin care management.

98. My expert advisor, RN Dawn Carey, stated:

> "Acknowledging the medical assessment on 16 [Month3] and the available contemporaneous wound assessments; it appears that [Mrs A's] right hip/thigh wound was being managed adequately. However, I am critical of the lack of accompanying reportage clarifying why dressings were not changed in accordance with the documented frequency. In my opinion, such incidences should be clarified by contemporaneous documentation. I acknowledge that not all my nursing peers would participate in such documentation.
>
> I consider that care provided in relation to management of her right hip/thigh wound to be consistent with accepted standards."

99. I accept RN Carey's advice that the care provided to Mrs A regarding her wound care was appropriate in the circumstances. However, I am concerned about the lack of documentation regarding the dressing of Mrs A's wound between 2 and 9 Month3. I agree with RN Carey that where dressings are not changed in accordance with the required frequency this should be clarified by contemporaneous documentation.

Pain management - Breach

100. Mrs A's PCCP was to be reviewed six monthly or as her needs changed. The pain care plan stated that Mrs A would be monitored for any signs of pain and that the

"interventions/support" was her analgesia as charted. This plan was last updated in March 2014 and was not updated towards the end of Month3 when Mrs A's condition was deteriorating.

101. Mrs A was prescribed codeine phosphate 30mg PRN for pain, up to once every four hours. Mrs A was also prescribed paracetamol 500mg (two tablets, twice daily) as a regular medication.

102. It was recorded that Mrs A experienced pain during her cares on 15, 21, and 22 Month3. It is recorded in the progress notes that on three occasions between 23 and 26 Month3, Mrs A requested pain relief for "pain all over".

103. Mrs A did not require PRN codeine between 16 and 21 Month3, but was administered it twice on 22 Month3, twice on 23 Month3, once on 24 Month3, and three times on 25 Month3. In my view, Mrs A's pain experience was changing from 22 Month3 onwards.

104. Despite RN C stating that all staff were aware to check on residents 20 minutes after giving pain relief to ensure it had worked, there is no documentation of any evaluation of the effectiveness of the PRN codeine on these dates. Gracelands' Pain Management Policy required the effectiveness of treatment to be evaluated and recorded in the resident's progress notes and pain monitoring tool.

105. Mrs A also received paracetamol, as prescribed, every day from 16 to 25 Month3 and an additional 1000mg paracetamol at 12.30pm on 24 Month3.

106. RN L recalls writing a note in Gracelands' hospital communication diary for the staff commencing the morning shift on 23 Month3 to contact Dr D and the hospice nurse for further direction regarding Mrs A's care. However, there is no record that Dr D or the hospice was contacted at that time.

107. The progress notes for 26 Month3 record an entry from Ms K stating: "Cares completed very sensitive and indicating signs of [excruciating] pain when showering … informed [RN M] nebuliser used for comfort, cares decline[d]." RN C then documented: "commenced on hourly pain chart". Neither entry has the time of documentation recorded, which makes it difficult to determine the timing of events during the day.

108. Mrs B told HDC that on 26 Month3 her mother telephoned her saying that she was in a lot of pain. Following this, Mrs B said that she spoke to RN M who told her that her mother was on her paracetamol regime and that he had just given her codeine, "which should kick in shortly", but he would get RN C to contact her (Mrs B).

109. RN C said that she next became involved in Mrs A's care when she was alerted by RN M that "more pain relief was needed". RN C telephoned Mrs B after checking on Mrs A. Mrs B said that RN C confirmed Mrs A was in a lot of pain, that she had commenced an hourly pain assessment tool, and that she would arrange for the doctor to come and visit. There is no record in the clinical notes of the telephone

conversations with Mrs B. In my view, clear records of communication with family should be recorded.

110. RN C sent a facsimile to Dr D noting that Mrs A's pain was 8/10 and that she was not prescribed enough analgesia. At 3.45pm that day, a medical centre nurse responded with an amended pain management plan to give 1g paracetamol four times daily, and 30mg codeine every four hours prior to cares. This plan followed discussions between a medical centre nurse and Dr N.

111. It is recorded that Mrs A received codeine at 12.15pm, 5pm and 9pm, and paracetamol at 8am, 5.35pm and 8pm on 26 Month3.

112. The pain assessment tool was filled in approximately hourly between 3pm and 8pm that day. I note that Gracelands' staff did not subsequently complete the pain assessment tool hourly. RN C told HDC that she was told Mrs A was asleep when she telephoned the unit that night, and RN L said that Mrs A had settled after 30mg codeine was given at 2.00am on 27 Month3.

113. RN J contacted Dr D on the morning of 27 Month3 regarding an acute flare up of Mrs A's condition and Mrs A was admitted to hospital later that day.

114. Regarding Mrs A's pain assessment RN Carey advised:

> "In my opinion, [Mrs A's] 'pain care plan' should have been updated to support regular monitoring and assessment of her pain experience. I am also critical of the lack of evaluation involved in [Mrs A's] pain management. In my opinion, an objective pain assessment tool should always be used when assessing pain and evaluating the effectiveness of PRN administered analgesia … In my opinion, incidences where interventions occur less frequently than specified – pain assessments not done hourly, analgesia not administered every four hours etc – should be clarified by contemporaneous documentation."

115. I accept RN Carey's advice. I am concerned that Mrs A's pain care plan was not updated as her condition deteriorated, and evaluation of the effectiveness of PRN codeine was not recorded, as required by Gracelands' policy. Furthermore, the pain assessment tool commenced by RN C on 26 Month3, was not filled in hourly. I accept that this was not filled in hourly overnight while Mrs A was noted to be settled, but in my view, this tool should have been recommenced on the morning of 27 Month3.

116. Regarding Mrs A's overall management, RN Carey advised:

> "[Gracelands'] nursing staff should have initiated communication with Mrs A's GP prior to 26 [Month3] and have communicated her changing condition – increased pain and increased skin breakdown. In my opinion these signs and symptoms were not acted on in an appropriate timescale."

117. I accept RN Carey's advice. I am critical that Gracelands' staff did not respond promptly to Mrs A's changed pain experience, and contact Dr D earlier.

Conclusion

118. Overall, RN Carey considered that the care provided to Mrs A moderately departed from accepted standards[15] in relation to pain assessment and management of pain. I agree.

119. In my view, it is evident that Mrs A's skin condition was deteriorating from 21 Month3, when she was experiencing pain during her cares and blood on her bed linen. I also note that from 22 Month3 Mrs A's pain experience was changing, as she required more PRN codeine and began requesting pain relief for "pain all over". However, Gracelands' staff failed to contact Dr D about either aspect of Mrs A's changing condition prior to 26 Month3. In addition, Gracelands' staff also failed to update Mrs A's pain care plan and document the effectiveness of administered pain relief appropriately. Accordingly, I find that Oceania Care Company Ltd did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: RN C – Adverse comment

120. As the Clinical Manager at Gracelands, RN C had responsibility to provide effective clinical leadership to clinical and care staff. RN C was required to personally check on critically unwell residents and work through plans of care with the RNs, put in place required monitoring, and arrange doctors' input.

121. On the fourth week of every month, RN C was required to check the usage of PRN medication and organise medication reviews for those residents using PRN medication regularly, she also had to check that staff were writing in the progress notes when giving PRN medication and were noting its effect.

122. RN C told HDC that, as a rule, she checked on each patient first thing in the morning and last thing before leaving in the evening, and she recalled that Mrs A was sleeping comfortably during most of these visits.

123. On 23 Month3, RN L discussed Mrs A's upper thigh wound and care with RN C, who arranged for clinical photographs to be taken.

124. RN C said she next became involved in Mrs A's care when she was alerted by RN M on 26 Month3 that more pain relief was needed. RN C reviewed Mrs A and spoke with Mrs B about Mrs A's condition. RN C told HDC that as soon as she became aware of Mrs A's pain, she instructed an hourly pain assessment tool. She stated that all staff were aware to check patients 20 minutes after providing pain relief to ensure it had worked. However, there is no record in the clinical notes that staff documented the effectiveness of Mrs A's PRN codeine between 22 and 25 Month3.

[15] Standards New Zealand (NZS), *8134:2008 Health and disability services standards* (Wellington: NZS, 2008).
Nursing Council of New Zealand (NCNZ), *Code of conduct*, (Wellington: NCNZ, 2012).

125. RN C initiated contact with Dr D on 26 Month3, noting that Mrs A's pain was 8/10 and that she was not prescribed enough analgesia. I consider that once RN C became aware of Mrs A's condition on 26 Month3, she acted appropriately by commencing a pain assessment tool and contacting Dr D. However, I note that this tool was not filled in hourly after 8pm. I accept that this was not filled in hourly overnight while Mrs A was noted to be settled, but in my view, this tool should have been recommenced on the morning of 27 Month3.

126. There is no evidence to suggest that registered nursing staff had raised concerns directly with RN C about Mrs A's overall deteriorating condition, namely her pain levels, prior to 26 Month3. However, in light of RN C's duties as outlined above, I consider that she should have been more alert to Mrs A's increased need for PRN codeine from 22 Month3 onwards.

127. Despite this criticism, overall, I am satisfied that the failings in the care provided to Mrs A regarding her pain assessment, pain management and failure to contact her GP in a timely manner prior to 26 Month3 were as a result of the care provided by Gracelands' staff generally and are overall attributable to Oceania Care Company Ltd rather than RN C.

Recommendations

128. I recommend that Oceania Care Company Ltd apologise to Mrs B for its breach of the Code. This apology should be sent to HDC for forwarding to Mrs B within three weeks of this report.

129. I recommend that Oceania Care Company Ltd arrange for further staff training at Gracelands regarding pain management and pain assessment, and provide HDC with evidence of completion within three months of the date of this report.

Follow-up actions

130. A copy of this report with details identifying the parties removed, except Oceania Care Company Ltd (trading as Gracelands Lifestyle Care and Village) and the expert who advised on this case, will be sent to the Nursing Council of New Zealand.

131. A copy of this report with details identifying the parties removed, except Oceania Care Company Ltd (trading as Gracelands Lifestyle Care and Village) and the expert who advised on this case, will be sent to the Ministry of Health (HealthCERT), the district health board, and placed on the Health and Disability Commissioner website www.hdc.org.nz for educational purposes.

Appendix A – Independent nursing advice to the Deputy Commissioner

The following advice was obtained from in-house nursing advisor, RN Dawn Carey:

"Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs B] about the care provided to her late mother, [Mrs A] by Oceania Gracelands (OG). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have reviewed the documentation on file: complaint from [Mrs B]; response from Oceania Group Limited (OGL) including an internal report and [Mrs A's] resident record; clinical notes from [the DHB].

I have reviewed the additional responses from Oceania dated 2 and 3 February 2015.

Background
Prior to her death, [Mrs A] was a resident at OG. She had a terminal skin condition, mycosis fungoides, which gave her symptoms of pain, bleeding, and pus weeping from nodules. She was undergoing weekly ultraviolet light treatments at [the DHB].

[Mrs A] was seen by a wound specialist on 27 [Month3], who agreed her skin condition was at an acute stage. Her pain was inadequately controlled with paracetamol and codeine, so a RN contacted the GP for further pain relief and a hospice referral on this day. The GP considered [Mrs A] should be admitted to hospital.

[Mrs A] was admitted to [the public hospital] on 27 [Month3], and deteriorated over the next few days. She died [in hospital] after being started on the Liverpool Care Pathway. [Mrs A] could not be embalmed due to the extent of the ulceration on her body.

Ms B has complained to HDC about the care provided by OG. She notes that her mother contacted her on 26 [Month3], saying she was in pain and her cares were being ignored. [Mrs B] considers:

Her [mother] would have had her final days in more comfort if the hospice had been contacted by OG earlier, and a palliative plan put in place.

She would have had a better idea of her mum's state if the OG caregivers were able to contact the family earlier.

A 'pain plan' should be in place as soon as deterioration is noted.

She does not direct her complaint at [the public hospital], but notes that during the night of 29/30 [Month3] there was a delay in obtaining a nebuliser, and that the hospital could not provide an air mattress as there were none available.

Advice request
I have been asked to review the [Mrs A's] resident file from OG; and to comment on the pain management, skin care management including wound care, and the timeliness of contact with the GP regarding pain relief and hospice involvement.

I have also been asked to review the nursing care provided to [Mrs A] at [the public hospital] and to report any concerns that I note.

I understand that a response from [the DHB] has not been sought.

I have reviewed the response from OGL including the internal report and submitted policies. For the purposes of brevity, I have chosen not to report the response details in this advice. In my opinion, the pain management policy (2012) and pressure area risk management and skin care policy (2012) are consistent with the relevant standards.

[…]

Review of [the public hospital's] clinical notes
The medication chart shows that a salbutamol nebuliser was *RN initiated* and administered at 7.40am on 30 [Month3] for [Mrs A]. Clinical notes report that this was administered *with excellent effect* and chosen as [Mrs A] could not use the prescribed Duolin inhaler. The morning ward round reports [Mrs B's] wish *…to have a plan for SOB – not managing inhalers, doesn't like nebs…*An agreed plan is documented.

There is no reportage concerning the type of mattress that [Mrs A] was cared for on at [the public hospital]. In my experience, it is common for hospitals to hire pressure relieving mattresses for patient use. I do note that [Mrs A] was admitted to [the public hospital at a busy time], which may have affected the ability of staff to access an air mattress for her use. I also note that there is evidence of nursing staff providing pressure area care to [Mrs A] and being diligent in assessing and managing her pain.

Review of OG resident file and relevant policies
Pain management
There is a Person Centred Care Plan (PCCP) on file that is dated 2014. This has not been signed by [Mrs A] or a member of nursing staff. Hip and hand pain is recognised as a long term concern in this PCCP and the need to monitor [Mrs A] for signs of pain is specified.

According to the submitted medication records, [Mrs A] was prescribed paracetamol 1gram twice daily (bd) as a regular analgesia. She was also prescribed codeine phosphate 30 milligrams (mgs) analgesia as a PRN (as required)

medication. In [Month2], codeine phosphate was administered to her on three occasions. From 22 [Month3] [Mrs A] was receiving this analgesia each day and generally more frequently than once per day.

On 21, 22 and 23 [Month3] heath care assistant (HCA) entries in the care progress notes (CPN) report [Mrs A] experiencing pain during her morning shower due to open lesions. Complaints of "all over" pain is also reported by the evening HCA on 23 and 25 [Month3]. Documentation reports increasing pain on 26 [Month3]*…indicating signs of excruciating pain when showering…*

CPN documentation reports [Mrs A] being *commenced on hourly pain chart* on 26 [Month3]. This is also written on the submitted pain assessment tool (PAT). *Cod. Phos every 4 hours* is documented as a specified intervention on the PAT at 3.20pm. I note that after 8.05pm [Mrs A's] pain score was only assessed once more – 2am – and that the codeine phosphate was generally administered at 5 hourly intervals.

Comments: Whilst it is reasonable that a long term resident's care plan is reviewed at six monthly intervals; health and professional standards[16] require acute changes to be managed promptly and reflected in a suitable care plan. I note the frequent RN entries in [Mrs A's] CPN that report *notes reviewed.* In my opinion, such a quality control measure is only valuable if the RN incorporates their clinical knowledge and competencies when reviewing the content of documentation entries by non registered health carers. In my opinion, [Mrs A's] 'pain care plan' should have been updated to support regular monitoring and assessment of her pain experience. I am also critical of the lack of evaluation involved in [Mrs A's] pain management. In my opinion, an objective pain assessment tool should always be used when assessing pain and evaluating the effectiveness of PRN administered analgesia. The use of an objective pain score tool acknowledges the research literature findings that pain is usually under recognised and under treated by health practitioners. In my opinion, incidences where interventions occur less frequently than specified – pain assessments not done hourly, analgesia not administered every four hours etc – should be clarified by contemporaneous documentation.

Skin care management

[Mrs A] skin condition meant that she required daily application of emollient and hydrocortisone (Locoid) cream to manage the associated symptoms. She also had a chronic right hip/thigh ulcer which required regular wound care.

There is a named RN responsible for overseeing [Mrs A's] wound care and for coordinating changes to dressing interventions.

Daily entries report staff consistently attending to [Mrs A's] skin care needs through application of her prescribed creams.

[16] Standards New Zealand (NZS), *8134.1:2008 Health and disability services (core) standards* (Wellington: NZS, 2008).
Nursing Council of New Zealand (NCNZ), *Code of conduct,* (Wellington: NCNZ, 2012).

A fax dated 25 [Month2] shows a referral to [the DHB] wound specialist nurse seeking input to manage [Mrs A's] ulcer, which the OG RN had assessed as having deteriorated.

The WA&MF for 1-16 [Month3] inclusive reports *frequency of monitoring: daily.* Entries indicating a change of dressing (COD) are not available for significant periods of time, up to six days. I note that there is also no reportage in the CPN that would indicate a COD had occurred during these periods.

[Dr D] reviewed [Mrs A] on 16 [Month3] as part of a routine three month health check. Her skin condition is reported as unchanged – *in status quo.*

19 [Month3]: Following HCA concerns about skin breakdown and new open lesions on [Mrs A's] body, a RN reviewed her skin integrity. RN documentation reports *many open areas located on various parts of her body.* The RN also reports reiterating the medical advice from 16 [Month3] recommending that Locoid cream should not be applied to broken skin.

There is no evidence that [Mrs A's] dressing was changed between 19-22 [Month3] inclusive when *every 3 days* is documented on the WA&MF.

22 [Month3]: HCA reports…*signs of blood* [on] *clothes and sheets*

23 [Month3]: Morning HCA reports a stronger odour but without additional information as to possible source. A RN reports a COD in the CPN with commentary that the care manager will photograph [Mrs A's] wound tomorrow. General description of wound is consistent with previous assessment. *A lot of blood on floor and bed again* is reported by the evening HCA.

24 [Month3]: [Mrs A] is reported as attending [the DHB] *for treatment…*

On 25 [Month3] [Mrs A's] hip wound was redressed as it was wet from exudate. Documented dimensions, wound bed and exudate levels are consistent with those from the previous week. Consistent with previous wound assessment documentation, the absence of wound odour is reported.

On 27 [Month3] two wound care specialist nurses reviewed [Mrs A] at OG. Their assessment is reported by OG staff; *mycosis fungoides is in an acute stage*. Management advice from a medical skin specialist is also reported.

Comments: [Mrs A's] general skin integrity appears to have deteriorated with noticeable blood loss being reported 22-23 [Month3]. In my opinion, this should have resulted in timely communication with her GP and probable input from a skin specialist.

The design of the WA&MF allows for wound assessment that is consistent with accepted standards. I note that when used it shows a comprehensive standard of wound assessment and monitoring. When managing chronic wounds I agree that it is important that changes are coordinated by one RN. I am unsure whether the

review on 27 [Month3] was the first review by the [the DHB] wound specialist nurse. I consider it appropriate that OG nursing staff sought specialist input when [Mrs A's] hip wound was noted to be deteriorating or non healing. In my opinion, [Mrs A's] condition would require specialist wound input as areas of ulceration would be prone to delayed healing with deterioration and necrosis common.

Acknowledging the medical assessment on 16 [Month3] and the available contemporaneous wound assessments; it appears that [Mrs A's] right hip/thigh wound was being managed adequately. However, I am critical of the lack of accompanying reportage clarifying why dressings were not changed in accordance with the documented frequency. In my opinion, such incidences should be clarified by contemporaneous documentation. I acknowledge that not all my nursing peers would participate in such documentation.

Communication with GP

Contemporaneous documentation reports [Mrs B] contacting OG on 26 [Month3]. *Phoned worried about her mother…she was in pain and her pain relief was not controlling her pain.* Subsequent communication between OG and the GP surgery is supported by a copy of a fax, which reports [Mrs A's] increasing pain and that she had been started on an hourly monitoring pain chart. [Mrs A's] analgesia plan was increased to paracetamol 1gramme four times per day (previously two times per day) and codeine phosphate 30mg four hourly.

Following the review by the [the DHB] wound specialist nurses a fax was sent to [Dr D] requesting a review of [Mrs A's] pain relief and a referral to hospice. [Dr D] reviewed [Mrs A] in person and discussed the need for hospital admission. This was initially refused by [Mrs A] but agreed to with input from her daughter.

Comment: In my opinion, there were signs and symptoms of [Mrs A's] overall condition deteriorating and that this was not responded to promptly by OG nursing staff. I am critical that it took a phone call from [Mrs B] on 26 [Month3] to cue OG nursing staff to consider the adequacy of [Mrs A's] prescribed analgesia; to initiate pain assessment and monitoring processes, and to communicate with [Mrs A's] GP surgery.

Clinical advice

Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements, and are supported by appropriate standards[17]. Following a review of [the public hospital's] clinical notes, I consider that the provided nursing care was consistent with accepted standards.

Following a review of the OG clinical notes; I am of the opinion that the care provided to [Mrs A] moderately departed from accepted standards in relation to pain assessment and management of pain. I am also of the opinion that OG nursing

[17] Standards New Zealand (NZS), *8134.1:2008 Health and disability services (core) standards* (Wellington: NZS, 2008).
Nursing Council of New Zealand (NCNZ), *Code of conduct*, (Wellington: NCNZ, 2012).

staff should have initiated communication with [Mrs A's] GP prior to 26 [Month3] and have communicated her changing condition – increased pain and increased skin breakdown. In my opinion these signs and symptoms were not acted on in an appropriate timescale.

I consider that care provided in relation to management of her right hip/thigh wound to be consistent with accepted standards.

The following further advice was obtained from RN Carey on 11 March 2015:

"Following a review of the additional responses I remain critical of the nursing care provided to [Mrs A] in relation to pain assessment and management of pain. I note that the nurses who had been involved in the direct management of [Mrs A] are no longer employed [at Gracelands]. I also note the remedial actions – education, daily monitoring and input from [the DHB's] wound care specialist – that have been implemented In my opinion, these actions are appropriate."

The following further advice was obtained from RN Carey on 15 February 2016:

"Thank you for the request that I review the additional responses and information received. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Following this review I have determined no cause to amend my previous advice – 9 December 2014, 11 March 2015 – on this case. I note that there is evidence that the corrective actions that have been completed by Oceania and Gracelands are yielding the desired positive results."