Ngati Porou Hauora Incorporated

Registered Nurse, Mrs B

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC18556)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

This report focuses on the care provided to Mrs A by Ngati Porou Hauora Incorporated (Ngati Porou Hauora) and Registered Nurse and Hospital Services Manager Mrs B, in mid 2007. Of particular concern to her whānau, Mrs A developed a large sacral pressure sore while she was a patient during this period.

Mrs A was transferred to a larger hospital, and on arrival, her sacral pressure sore was described as very large, infected, and necrotic.[1] Despite treatment, Mrs A's condition deteriorated and she died.

This report considers whether an appropriate standard of care was provided to Mrs A, in particular whether the risk to her pressure areas was accurately assessed and managed.

Complaint and investigation

On 23 October 2007, the Health and Disability Commissioner (HDC) received a complaint from a Health Consumer Service advocate on behalf of Mrs A's whānau, about the services provided to her by Ngati Porou Hauora.

The following issues were identified for investigation:

- *Did Ngati Porou Hauora Incorporated provide an appropriate standard of care to Mrs A?*

- *Did Registered Nurse Mrs B provide an appropriate standard of care to Mrs A?*

The parties involved in this case are:

Mrs A (dec)	Consumer
Ngati Porou Hauora	Provider/Employer/Māori Health Care Trust
Mrs B	Hospital Services Manager / Registered Nurse
Dr C	General Practitioner
Dr D	General Practitioner
Dr E	General Practitioner
Dr F	General Practitioner
Dr G	Geriatrician
Mr H	Locum physiotherapist
Ms I	Registered Nurse

[1] Affected by necrosis (death of cells). The skin layers around the wound were "breaking down".

Ms J	Registered Nurse
Ms K	Registered Nurse
Ms L	Registered Nurse

Independent expert advice was obtained from Registered Nurse Janet Maloney-Moni, a specialist in Māori primary health care (see Appendices A and B).

Relevant information

The Hospital
The Hospital has 11 beds and offers both long-term residential care and short-term respite/day care. The Hospital is owned by Ngati Porou Hauora.

Mrs B
Mrs B had been employed as Ngati Porou Hauora's Hospital Services Manager from July 2006. The Hospital Services Manager's duties and responsibilities include:

> "2. Leadership: ... ensure practice and service ... are consistent with regulations, professional standards and are based on evidence for best practice.
>
> ...
>
> 10. Quality: ... Provision of services of [a] high standard at all times."

Mrs B's role as Hospital Services Manager was combined with her responsibilities as a registered nurse, working rotating shifts with five other registered nurses. Mrs B retired from her position as Hospital Services Manager on 18 April 2008.

Mrs A
Mrs A was 72 years old and weighed 140kg at the time of her admission to the Hospital in mid 2007. Mrs A was being cared for by her two sons at home before her admission, and suffered from morbid obesity, diabetes, hip pain, high blood pressure, gout, and breathing difficulties. She also suffered from hallucinations, caused by Charles Bonnet syndrome.[2]

Mrs A's General Practitioner, Dr C, visited her at home and noted that she was able to sit up in bed, stand, and walk several steps with assistance. He believed that there was "no absolute factor preventing her from being mobilised".

[2] Charles Bonnet syndrome is characterised by complex visual hallucinations alongside deteriorating vision, usually in people who are elderly. It is not related to psychosis or other mental illness.

Admission to the Hospital
Mrs A was admitted to the Hospital a few days later (Day 1) because of concerns from her family and Dr C about her lack of mobility. She had been bedridden for months, only getting out of bed to go to the toilet. Dr C stated that he "envisaged that [Mrs A] would ... return home with anticipated increase in care arrangements". Dr C continued to see Mrs A intermittently at the Hospital.

Medical assessment
General practitioner Dr D briefly assessed Mrs A when she was admitted to Hospital and noted that she had been admitted for "assessment" and possible pool therapy to assist with mobilisation. Dr D also requested that an X-ray of Mrs A's left hip be arranged for the following Monday (Day 6).

Nurse assessment
Registered Nurse Ms I completed an admission assessment of Mrs A and recorded her findings on a Patient Flowchart, which described the care plan. She noted Mrs A's weight, and that an X-ray was planned for Day 6. Ms I also documented that Mrs A required regular pain relief (paracetamol) and that her blood sugar levels were to be monitored before (strict diabetic) meals, although she did not record acceptable limits. The patient flowchart also identified that Mrs A required assistance to mobilise with a walking frame, and with activities of daily living.

Ongoing care
Overnight, Ms I documented that Mrs A required "very little assistance" with toileting.

On Day 2, Mrs A was suspected to have a urinary tract infection, and a urine specimen was sent to the laboratory. This was noted in the Patient Flowchart, and a urinary tract infection was confirmed the next day.

Mrs A also complained of pain in her left heel, and this was relieved by placing pillows under her heels. In their letter of complaint, Mrs A's whānau alleged that her heels were injured when she was dragged backwards in a wheelchair without foot-rests. Ngati Porou Hauora has accepted that this occurred.

On Day 3, staff reported that Mrs A was able to mobilise to the shower and toilet (using a walking frame and assisted by two nurses), and stand while being showered. However, an incident report completed by Registered Nurse and Hospital Services Manager Mrs B noted: "While being mobilised back to her room ... [Mrs A] seemed to lose power in her legs and she gradually slipped to the floor/onto her knees."

Mrs A was moved to a bed that used electric motors to change the height and backrest, so that she could adjust her position independently. A standard mattress was used.

Review by Dr D
On Day 4, Mrs A was again assessed by Dr D, who noted that she was unable to bear her own weight unaided, and her two sons were required to assist with transferring her to the shower. Dr D noted "will need to see if she can be mobilised". Dr D referred Mrs A to the physiotherapist for toning exercises and prescribed antibiotics for her urinary tract infection.

Mrs A was sponged in the morning, and her sons assisted with lifting her to the shower in the afternoon. She reported pain in her right hip, knee and ankle in the morning, and Dr D prescribed regular paracetamol. Mrs A did not complain of further pain throughout the day.

Overnight, Mrs A complained of knee pain, but this was relieved with massage. Nursing staff documented in the clinical notes: "[pressure area care][3] to sacrum discomfort". No follow-up care plan for the sacral area was documented.

On Day 5, Mrs A was seen by General Practitioner Dr F, who noted that "... her overall condition is good". Registered Nurse Ms L documented in the progress notes that Mrs A was "able to weight bear [with] two staff for safety only [and] medium assistance" and change position in bed with assistance.

The next morning, however, Mrs A was described as "very drowsy [and] non co-operative" and unable to weight bear. She could not be showered, and was instead washed in bed. The Registered Nurse documented in the progress notes "[pressure area care] maintained. [Complained of] sore bottom" and paracetamol was administered to good effect. Although she was more alert in the evening, Mrs A was able to weight-bear for short periods only and was "very unsteady on her feet". The patient flowchart for Days 5 and 6 stated "shower" against the section relating to pressure area care, but the flowchart was not updated to include Mrs A's unsteadiness when mobilising, inability to weight bear, and sacral pressure pain. A gel pad was placed under Mrs A's right heel.

Dr E's assessment
On Day 6, Mrs A was assessed by General Practitioner Dr E. He decided to discontinue the antibiotics because they were causing Mrs A gastrointestinal upset/diarrhoea. Dr E documented that planning for Mrs A's discharge home ought to commence, noting that this would require a "good bed/hoist and training for [her] family".

Mrs B documented in the progress notes that Mrs A was incontinent of faeces in the morning, and an attempt to mobilise resulted in Mrs A sliding to the ground, and six people (mostly non-clinical staff members) were needed to lift her to a chair. No incident form was completed for this episode, and Mrs A was returned to bed later in

[3] There is no description of what the pressure area care entailed, in the progress notes or Flowchart.

the day and washed in her bed. Although she was due to have an X-ray of her left hip at 2pm, it was deferred because she was unable to mobilise or stand.

Physiotherapy assessment — request for pressure mattress
On Day 7, Mrs A was assessed by physiotherapist Mr H. Mr H had been asked to assess Mrs A for toning exercises and to determine her ability to safely mobilise from her bed to a chair.

Unfortunately, Mr H did not record his assessment in Mrs A's clinical notes, and his assessment and recommended strategies to maintain a safe environment for Mrs A and staff were not reported until Day 21.

The next morning, nursing staff gave Mrs A a sponge bath, and repositioned her in bed. The progress notes indicate that Mrs A was provided with pressure area care, although it is unclear what this entailed. Registered Nurse (RN) Ms J also documented in the progress notes "small grazed areas from ? previous fall and bruising", and applied a dressing. However, the notes do not state the location of the grazes, a Wound Assessment and Treatment Form was not completed, and the wound was not documented on Mrs A's patient flowchart. Mrs A continued to suffer from diarrhoea and faecal incontinence.

On Day 9, Dr D assessed Mrs A and noted "[she] is becoming a concern in terms of lifting ... requires her sons to ... assist nurses with lifting". Dr D noted that the best outcome for discharge would be for Mrs A to return home. Dr D discontinued Mrs A's diabetes medication to see if her diarrhoea would improve. RN Ms J cared for Mrs A in the morning and documented applying "Betadine to broken areas" and maintained Mrs A on fluids only.

In the afternoon, the Hospital received an email from Mrs A's daughter, expressing dissatisfaction that her brothers were continuing to care for their mother. She considered this to be the hospital's sole responsibility.

However, Dr C advised:

> "[T]he use of family members to assist with patient cares during rehabilitation ... is quite common in our setting, as family members would normally be involved in further care at home. Continuing family encouragement and support while in hospital was considered very important for [Mrs A's] recovery. It also provides a valuable opportunity for family members to work alongside the trained hospital staff, adding to their skills and techniques which can then be applied once they are back providing the ongoing care at home."

On Day 10, Mrs A was assessed by Dr C. He noted that the X-ray table at the Hospital could not support Mrs A and he would contact a hospital in a larger centre (Hospital 2) to arrange for X-rays to be taken there. He documented:

> "[Mrs A's] mobility is poor and I suspect general deconditioning of leg muscles (and generally whole body) from periods of immobilisation, to be the main cause. Her obesity contributes greatly ..."

The progress notes for that day document a "reddened area" on Mrs A's buttocks, and that she was provided with pressure area care (again, not specified), rolled onto her side, and propped up with pillows. Mrs B documented that although Mrs A was "just able to weight bear on standing", it was not possible to shower her.

Pressure area care
The patient flowchart for Days 9 and 10 noted that it was "not possible" to shower Mrs A and she was bed sponged instead. Her skin was described as "intact", and the mobilisation section was ticked to indicate that Mrs A was on bed rest, and use of a high-frame as a mobility aid was deleted.

On Day 11, the progress notes document a broken area of skin under Mrs A's breast, to which Betadine was applied. The size of the wound was not identified, and a Wound Assessment and Treatment Form was not completed. Pressure area cares were documented as having been given, although specific details were not noted.

On Day 12, Mrs A's sacrum was described in the progress notes as "red", and Betadine was applied. The progress notes state: "[pressure area care] maintained [with] pillows … Pillow placed under bottom to keep off sacrum. Please check each duty."

The patient flowchart stated "bed sponge" against the pressure area care section for Days 11 and 12, and that Mrs A's skin was intact. It was noted that she was still to be immobilised on bed rest.

On Day 13, the progress notes state "[pressure area care] maintained", with no details of the care provided.

On day 14, the nursing record again states that pressure area care was "maintained", and Betadine was applied to Mrs A's sacrum.

The patient flowchart for Days 13 and 14 stated "PRN" (meaning "as required") against the pressure area care section, and that Mrs A's skin was "frail" and "broken". Betadine was applied to the (unidentified) broken skin, and Micreme was applied under her left breast. Mrs A was still immobilised on bed rest, but a high pulpit frame was being used to assist her to stand when transferring to a chair.

Although Mrs A's pressure areas were obviously deteriorating, transfer to a specialised roller-bed to relieve pressure from vulnerable areas, and assist nursing staff to turn Mrs A regularly, was not arranged. Mrs B advised:

> "It may be suggested that [the roller-bed] system should have been implemented at an earlier point for [Mrs A]. However, its use would have been contrary to the purpose of [Mrs A's] hospital stay and the medical orders for her mobilisation.
>
> ...

> [T]he roller sheet system allows the patient almost no independent movement. It severely restricts the patient's independence and self-directed mobilisation."

Pressure area risk assessment

On Day 15, a pressure area risk assessment was performed, for the first time, using a Waterlow Scale.[4] The nurse recorded that Mrs A's score was 14, indicating that she was at risk of pressure sores. (There is further comment on this assessment below.) The progress notes indicate that pressure area care was "maintained".

On Day 16, the progress notes and patient flowchart document that the broken area on Mrs A's sacrum was cleaned with Betadine and a protective dressing placed on it. The patient flowchart stated "PRN" against the pressure area care section, and Mrs A's skin was noted to be "frail" and "broken".

On Day 17 the progress notes describe that Mrs A was transferred to a chair "to give her sacrum a rest, as lying in bed for long periods of time is causing her sacrum to go red". She was encouraged to sit to reduce the chance of a sacral pressure sore occurring, and her family was advised of this.

Later that day, Mrs A's two sons attempted to assist Mrs A back to bed, but she slipped to the floor, unable to weight-bear. She was assisted back to bed for the second time, by six people (an ambulance officer, three staff, and her sons). An incident form was completed by Registered Nurse Ms K. The progress notes document "[pressure area care] maintained", and it is recorded that the sacral dressing was changed. Dr C assessed Mrs A in the evening and noted bruising and broken skin on her buttocks and 4th right toe. He ordered "usual management for [reducing] pressure on sacrum".

On Day 18, it was documented in the progress notes "… [D]ressing to sacrum cleaned and changed. [Three dressings] remain in situ on buttocks. Broken area on sacrum. [Pressure area care] maintained". Dr C also wrote to geriatrician Dr G, requesting that he assess Mrs A. Dr C outlined Mrs A's current medical condition and noted: "She had an Occupational Therapist assessment recently [and] a period in the rehab ward was suggested. We would like your endorsement on this as we lack the manpower and equipment such as hoists and regular physio to efficiently manage her."

Family meeting

A meeting was held with six members of Mrs A's whānau to discuss her health and management, including the difficulty in caring for Mrs A because of her weight, and limited mobility. Dr C recalls discussing the circumstances of Mrs A's falls and injuries sustained, and ongoing management of her pressure areas. Whānau members questioned whether transfer to Hospital 2 for rehabilitation would be appropriate, and it was decided that Mrs A's suitability would be assessed by Dr G on Day 21 (Dr G's

[4] The Waterlow Scale is a tool to measure the risk of developing a pressure sore. Risk factors (such as BMI, skin condition, gender, age, continence, mobility, etc) are assessed and scored depending on their seriousness. The individual scores are added and the overall score indicates the risk of developing a pressure sore. A score of 10–14 indicates risk; 15–19 indicates high risk; 20+ indicates very high risk.

clinic was later postponed to Day 22). Dr C recalled that there was a consensus that active mobilisation would be avoided in the meanwhile, and that care would be basic and aimed at pressure area management. He stated:

> "I did not believe there was any reason to acutely refer [Mrs A] to hospital at this stage, and the family members agreed to await [Dr G's] assessment."

However, in their response to my provisional opinion, Mrs A's whānau recalled that "we asked for mum to be moved to [Hospital 2] but we were told that 'there is no medical reason to move her [there]'".

Later that day, Mrs A's sacral area was redressed, and it is recorded that a pillow was placed under her mattress to keep her on her side. Foam heel boots were also placed on Mrs A's feet to alleviate pressure. Her right heel was reported to require a gel pad.

The patient flowchart stated that Mrs A was to have pressure area care every six hours, and that Betadine and Micreme were applied to the broken skin on her sacrum and 4th right toe. The mobilisation section was also updated to indicate that Mrs A was not to be lifted and was on full bed rest.

On Day 19 it was recorded that Mrs A's buttocks were "breaking down". It is recorded that pressure area care was "maintained", again with no detail of the care.

Transfer to roller bed

On Day 20, because of her deteriorating pressure areas, Mrs A was transferred onto a special bed that used a roller system to allow a patient's position to be changed regularly by staff. A chart was commenced for documenting Mrs A's changes of position, and this indicated that she was turned frequently but irregularly. A wound Assessment and Treatment Form was also commenced, and indicated that the skin surrounding Mrs A's sacral pressure sore was fragile and inflamed, with blood exudate.[5]

Mrs B stated that "[t]he electric roller sheet bed with the pressure mattress was introduced ... following Mrs A's confinement to full bed cares."

On Day 21, physiotherapist Mr H reported his assessment of Day 7. He concluded that Mrs A was unable to walk, supported or unsupported, for any distance because of muscle weakness and weight. He considered that Mrs A ought to be assessed by Dr G, geriatrician, for transfer to Hospital 2's rehabilitation ward. Mr H noted strategies in place to maintain a safe environment for Mrs A and staff, including that she had been transferred to a bed with a pressure-relieving mattress and roller-bed sheet adjustment system, to allow for regular turning.

[5] Exudate is a thick discharge associated with open wounds.

The patient flowchart stated "obese" in the section relating to pressure area care, and documented that Mrs A required six-hourly turns.

Mrs A is recorded as suffering from further diarrhoea on [Day 21], and she was turned every 1½–4 hours. Over the next few days Mrs A was turned reasonably frequently, but there were times when there was not documentation to indicate that her position was changed for up to 10½ hours. The dressings to her sacral pressure sore were changed at least daily, and she was assisted with all nursing cares.

On Day 22 Mrs A was assessed by Dr G at the Hospital, with a view to rehabilitation at Hospital 2. Dr G was "uncertain if [Mrs A] would be able to undertake rehabilitation due to confusion and [lack of] motivation". He discussed with Mrs A's sons his concerns and the risks involved in active mobilisation, and stated that if she were transferred for rehabilitation, it would be for a two-week trial. If unsuccessful, she would be transferred back to the Hospital.

On Day 23 it was recorded that Mrs A's sons would discuss the suggested trial of rehabilitation with their mother. Mrs A continued to be turned frequently but irregularly, and her pressure areas were cared for according to the plan in the patient flowchart. Solusite gel was applied to the sacral pressure sore, to dissolve the dead tissue. In her response to my provisional opinion, Dr D advised that "[w]hen Solusite gel is applied, it dissolves the dead eschar tissue by breaking it down and in the process creates an odour ... [t]he fact that there is odour does not always mean there is infection".

On Day 24, Mrs A's sacral pressure wound was suspected to be infected and, in addition to standard wound care, a swab was taken. By [Day 25], the sacral wound was described as infected and smelling offensive. Dr E examined Mrs A and prescribed oral antibiotics. He also asked for Mrs A's diabetic medication to be continued, despite causing diarrhoea, as lower blood sugar levels would assist healing of the pressure sore.

On Day 26 it was decided to transfer Mrs A to Hospital 2 for a surgical review of the pressure sore.

Hospital 2

The care Mrs A received at Hospital 2 was set out in the discharge summary completed following her death.

Mrs A was described as having been referred with "a very large sacral pressure wound which had developed over the preceding two to three weeks". Mrs A was described as "very unwell" on arrival, with a "very large, infected, offensive smelling necrotic sacral pressure wound extending across the [upper] portion of both buttocks". (The wound was described as being 25cm x 25cm on Day 31.) She was found to be in acute renal failure, and septicaemic.[6] It was decided not to perform surgery to the wound, as

[6] Septicaemia is a systemic infection of the blood.

it was felt that Mrs A's death was "imminent". However, her condition stabilised, and a limited debridement[7] of her sacral wound was performed on the ward. Following surgery, Mrs A's condition deteriorated, and she died a few days later.

Waterlow score

As stated above, Mrs A's risk of developing a pressure sore was not calculated formally until Day 15, when a score of 14 was recorded (see copy of form at Appendix D). However, the form used by the Hospital obscured the score for diabetes[8] and it was overlooked by the nurse conducting the assessment — using the Waterlow scale, a score of 4–6 is assigned if a patient has diabetes because of the increased risks associated with the condition.

In addition, Mrs A developed urinary and faecal incontinence by Day 15. The score she had been assigned was 1 (for "occasional incontinence"), rather than 2 (for "catheter/incontinent of faeces") or 3 (for "doubly incontinent").

By Day 15, Mrs A was unable to weight-bear, and was either in bed or sat in her chair. However, she was assigned a score of 3 for "restricted" mobility, rather than 4 for "inert/traction", or 5 for "chairbound".

The form used by the Hospital indicated that 10–14 was "at risk", 15–19 "high risk", and above 20 "very high risk". My expert advised that "an accurate assessment [of Mrs A's pressure area risk] would have placed her in the very high risk score of 20+."

Ngati Porou Hauora advised that, at the time of Mrs A's admission, no formal Waterlow assessment tool was available to assess a patient's pressure area risk, and the staff member who completed Mrs A's Waterlow assessment had used the tool in another country.

Mrs B advised that a Waterlow assessment tool was in the process of being introduced at the time of Mrs A's assessment but, due to difficulties in obtaining a specialist wound-care nurse to provide training to the Hospital's nursing staff, this was delayed.

The Hospital has subsequently introduced a new Waterlow form that allows for a more thorough and user-friendly assessment (see Appendix E), and has trained nursing staff in its use.

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[7] Debridement is the removal of necrotic, infected or foreign material from a wound.

[8] The score has been pushed (presumably by computer action) onto a new line and aligned left, so it does not correlate to the diabetes risk-factor.

Responses to provisional opinion

The majority of the parties' comments on my provisional opinion have been incorporated into the previous section. Remaining comments are outlined below:

Mrs B
Mrs B agreed that documentation of the care provided to Mrs A was "inadequate and poor". She stated that:

> "[a]s a result [of poor documentation] the standard and quality of care actually provided to [Mrs A] by members of the nursing staff ... was not evident or clear.
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> ...
>
> In [Mrs A's] morbid obese state [nursing cares, bed sponge, bed cares, personal cares] including [pressure area care] was required on each occasion. Pressure area care included the usual bony prominences. ... These procedures often took up to ¾ to 1 hour to complete using two and often up to three nurses. ... Minimising her pressure area risk was our biggest challenge 24/7."

Through her legal advisor, Mrs B stated:

> "[Mrs B] only took over as Hospital Manager in June 2006. She found on arrival that a number of policies were not at the modern level which she would have liked. ... [she] recognised the need to amend the policy regarding pressure area risks and care, and this was in the process of happening."

Mrs B advised that, since Mrs A's death, the following improvements have been made:

1. All hospital policies are reviewed and signed off annually;
2. All new admissions are assessed using a revised Waterlow Risk Assessment Chart;
3. All patient Care Plans now include a Waterlow Assessment score;
4. The Hospital has achieved Te Wana (Approved Quality Programme) accreditation.
5. Nursing and Medical staff have received competency-based practice and performance appraisals using the Nursing Council and Royal New Zealand College of General Practitioners competency standards.
6. Funding has been approved for staff training, including accessing appropriate external resources, including trainers and presenters.
7. Funding has been approved for accessing patient lifting equipment to maximum capacity, where necessary.

Dr D
Dr D supported Mrs B's account of the care that was provided by nursing staff to Mrs A:

> "[Mrs A's] care took priority over all the other patients. In order to undertake her full personal cares required (including cleaning, wound care management, bed toileting and repositioning so that she could be comfortable...) it would often take ¾ of an hour to one hour at each change.
>
> Her care required at least three nurses per time to change her and attend to her. ... During her admittance if she became incontinent of faeces or urine once her cares had been attended to, the nurses would again attend to her cares to ensure that at all times she was kept in the best possible state of cleanliness and comfort."

Dr D also commented on the decision to nurse Mrs A at the Hospital after she developed a sacral pressure sore:

> "[Dr G's] assessment note is quite clear that he was reluctant to recommend that [Mrs A] be transferred to [Hospital 2].
> ...
> [T]hat [Mrs A] could be transferred to [Hospital 2] as a **preventative** measure prior to her pressure wound becoming acute, unfortunately does not reflect the reality of the situation at [Hospital 2]. Had [Mrs A] been transferred to [Hospital 2] prior as a preventative measure, she would have been transferred back again."

Dr D noted that she was "...very sad to hear that [Mrs A's] condition had deteriorated and express my deepest condolences to her family".

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

…

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

Opinion

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

Breach — Ngati Porou Hauora

I am satisfied that, in general, the care provided to Mrs A was of an appropriate standard. Furthermore, it seems that every endeavour was made to provide care in a culturally appropriate manner.

However, in the important aspect of pressure area care, the staff of the Hospital provided a poor standard of care to Mrs A. Accordingly, I consider that Ngati Porou Hauora breached Rights 4(1) and 4(3) of the Code of Health and Disability Services Consumers' Rights (the Code), as it failed to provide Mrs A services with reasonable care and skill, and in accordance with her needs.

Pressure area care and documentation
It should have been clear to nursing staff on her admission to the Hospital that Mrs A's pressure areas were at risk. Her particular risk factors were a weight of 140kg, diabetes, and limited mobility, yet no pressure area risk assessment was completed. Although nursing staff could reasonably be expected to conduct a pressure-area assessment on admission, this failure was exacerbated by the admission documentation in use at the time, which did not prompt an assessment. My expert advised:

> "[Mrs A] ... was not adequately assessed for her high need for [pressure area care] on admission."

As Mrs A's admission progressed, she became doubly incontinent and even less mobile to the point where, by Day 15, she was immobile apart from being moved (with considerable assistance) from bed to chair, and back again. Mrs A's sacral area was identified as causing discomfort two days after admission. On Day 8 a broken area was noted on Mrs A's sacrum; on Day 12 the area was being treated with Betadine, and on Day 16 a dressing was applied. It was only on Day 20, by which time the condition of her sacral pressure area was worsening, that she was transferred to a special-purpose roller bed that allowed staff to change her position regularly.

Although I understand that Mrs A was admitted to the Hospital for rehabilitation, and the aim was to keep her as mobile as possible, the deterioration of her sacral pressure area and total inability to hold her own weight from Day 15, indicate that her management and care plan needed review. Having been confined to full bed-cares from Day 18, clearly the purpose of Mrs A's admission was no longer rehabilitation, but pressure-area management and comfort care.

Both Mrs B and Dr D advised that Mrs A was provided with regular, thorough, and time-consuming pressure area care throughout her admission to Hospital.

Mrs B acknowledged that much of this care was not documented in the clinical notes and "as a result the standard and quality of care actually provided to [Mrs A] ... was not evident or clear".

Although I accept that Mrs A was provided with regular pressure-area care, which was not always documented in the progress notes or patient flowchart record, there was no structured plan to manage the risk to her pressure areas. As a minimum, a structured pressure area care plan, detailing exactly what care was to be provided and when, should have been developed on admission, and amended as Mrs A's condition deteriorated and she developed an obvious sacral pressure sore.

Instead of referring to a pressure area care plan, irrelevant entries such as "obese" and "showered" were documented in relation to pressure area care. In fact, the haphazard nature of the recording of pressure area care concealed the transfer of Mrs A to a special bed on Day 20 — in short, there is no record of this transfer in the patient flowchart.

Waterlow score

The Waterlow Scale is a commonly used tool to identify patients at risk of developing pressure sores. This allows nursing staff to provide the correct resources. In Mrs A's case, her risk of developing pressure sores was not formally assessed until Day 15, over a week after a broken area had been identified on her sacrum. My expert advised that this assessment should have taken place at an earlier stage and, in my view, with a patient who was clearly at high risk, such an assessment should have taken place on

admission. This would have been in accordance with Ngati Porou Hauora's Skin Care Policy (the Skin Care Policy), which states:

> "... On admission, a Waterlow risk assessment will be completed on all individuals.
>
> ...
>
> Re assessment will be completed using the Waterlow risk assessment form when necessary or at least [every] six [days].[9]"

Although this policy was in effect from July 2006, Ngati Porou Hauora advised that at the time of Mrs A's admission, no formal Waterlow assessment tool was available to assess a patient's pressure area risk, and Mrs B advised that nursing staff had not received training in Waterlow assessment.

To compound the error of failing to perform an assessment at admission, when the assessment was performed it was significantly inaccurate. The nurse who performed the assessment calculated that Mrs A's score was 14, indicating "at risk". However, my expert advisor has calculated an actual score of over 20 — placing Mrs A in the "very high risk" category. In my view, Mrs A was clearly at high risk of developing pressure sores.

Although it is not the only inaccuracy on the form (see Appendix D), I am particularly concerned that the score for diabetes has been obscured, which significantly raises the risk level. In this case, a nurse noted that Mrs A had diabetes, but did not allocate a score for the condition. It is discomfiting to consider that other patients in the Hospital may have been similarly inaccurately assessed. To circle a risk factor (such as diabetes) without assigning a score is unhelpful, and the absence of a suitable template increases the likelihood of this occurring.

Because of my concern, this issue was brought to the attention of Ngati Porou Hauora during the investigation, as there was a significant possibility that patients assessed using this form would have their risk status miscalculated. Ngati Porou Hauora advised that a new Waterlow assessment form (incorporated into new admission and care-plan forms) was implemented in November 2007.

Summary

Throughout her stay at the Hospital, Mrs A's pressure area care was poorly documented and inadequately planned. Despite Ngati Porou Hauora policy, there was no formal initial assessment that would warn of a high risk (although the risk was obvious), and the subsequent — and late — assessment was significantly inaccurate.

When damage was noted to Mrs A's sacrum, inadequate measures were taken to reduce the risk of further damage. In particular, she was not transferred to a roller bed

[9] See appendix C. The Skin Care Policy (reviewed July 2006) is not always clear, and includes many incomplete sentences.

until Day 20 — over two weeks after admission and over a week since her sacrum was showing obvious signs of deterioration.

Furthermore, documentation of the care provided to Mrs A was poor, especially with regard to pressure area care, and instructions for turning her were not followed after she was moved to the roller bed.

I do not consider that the standard of pressure area care provided to Mrs A was reasonable, nor was it provided in a manner consistent with her obviously high needs. Accordingly, I consider that Ngati Porou Hauora breached Rights 4(1) and 4(3) of the Code.

Breach — Mrs B

As the Hospital Services Manager of the Hospital, Mrs B was responsible for ensuring that an adequate standard of care was provided to Mrs A during her admission, and that appropriate procedures were in place to assess and manage her risk of developing pressure sores. The Hospital Services Manager's duties and responsibilities include:

> "2. Leadership: ... ensure practice and service ... are consistent with regulations, professional standards and are based on evidence for best practice.
>
> ...
>
> 10. Quality: ... Provision of services of [a] high standard at all times."

Mrs B also directly cared for Mrs A as a registered nurse. Mrs B worked 15 shifts during the 26 days Mrs A was admitted to Hospital, providing her with ample opportunity to assess and manage Mrs A's pressure area care, and ensure that the Skin Care Policy was followed.

Pressure area assessment and management
As discussed above, Mrs A's pressure area risk was not objectively assessed until Day 15, and a structured plan to manage the risk to her pressure areas was not developed until after she had developed a serious pressure sore.

I accept that Mrs B had not held the position of Hospital Services Manager for very long when Mrs A was admitted, and was therefore not responsible for existing problems with Hospital policy, staff training and documentation templates. However, Mrs B was responsible for ensuring that patients were provided with care of a reasonable standard.

Accordingly, Mrs B is accountable for the poor standard of documentation relating to pressure area care, and lack of a structured plan to manage and re-evaluate the risk to Mrs A's pressure areas during her admission. It is not enough for staff to simply document that pressure area care was given, without any explanation of what the care consisted of.

It is especially disappointing to note that Mrs B was personally involved in Mrs A's care over 15 shifts, yet failed to recognise obvious deficits in documentation and pressure area assessment, management and treatment. Mrs B failed to ensure that pressure area care was provided to Mrs A with reasonable care and skill, and in accordance with her needs. Accordingly, I consider that Mrs B breached Rights 4(1) and 4(3) of the Code.

Other comment

Physiotherapist review and report
Mrs A was assessed by physiotherapist Mr H on Day 7. However, Mr H did not record his assessment in Mrs A's clinical notes, and no report was added to Mrs A's clinical notes until Day 21. I have been advised that Mr H was on sick leave between Days 8 and 21 with an acute illness, and so reported his assessment of Mrs A as soon as he returned to work.

I do not think that a delay of 14 days before receiving Mr H's report was acceptable. Staff at the Hospital should have either contacted Mr H for a verbal report, and documented this in the notes, or had Mrs A re-assessed by another physiotherapist.

Equipment
Ngati Porou Hauora advised that, at the time of Mrs A's admission, the hoist available for moving patients had a maximum capacity of 127kg. At 140kg, Mrs A was too large to be moved using the hoist, and Hospital staff and her sons lifted her instead. Dr C advised:

> "The main aim during [Mrs A's] admission was to attempt to reverse her de-conditioning and therefore gradual exposure to weight bearing activities was part of obtaining this goal.
>
> ...
>
> [T]he use of family members ... is quite common in our setting, as family members would usually be involved in further care at home."

I appreciate that the aim of Mrs A's admission was to increase her mobility, and am satisfied that her sons' continued assistance with lifting and cares was appropriate. However, I believe that the decision to admit Mrs A without appropriate lifting equipment on hand was ill advised, and may have placed Mrs A, her sons, and Hospital staff at risk of injury. When Mrs A was confined to full bed rest on Day 18, it

was no longer viable for her to remain at the Hospital without appropriate lifting equipment, and she should have been immediately transferred to Hospital 2.

Ngati Porou Hauora advised that it has now sourced a facility for renting lifting equipment that can carry patients up to 200kg in weight.

Heel injuries
I am concerned to hear that Mrs A was mobilised on a wheelchair without foot rests, especially as she was unable to lift her feet independently while in a seated position. Mrs A's family believe that the cause of the reddened area on her left heel was a carpet burn, resulting from Mrs A's bare heels being "dragged very fast backwards".

This is yet another example of Ngati Porou Hauora's failure to provide Mrs A with appropriate equipment to mobilise safely.

Recommendations

I recommend that Ngati Porou Hauora:

- Apologise to Mrs A's whānau for its breaches of the Code. The apology is to be sent to HDC for forwarding.
- Provide urgent training to all nursing staff on the assessment of risks to pressure areas and subsequent care planning/re-evaluation.
- Develop a policy, and provide staff training, on the specific care needs of obese patients.
- Obtain an independent review of the resources available for the management of patients at risk of developing pressure sores.

I recommend that Mrs B:

- Apologise to Mrs A's whānau for her breaches of the Code. The apology is to be sent to HDC for forwarding.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand and the District Health Board.

- A copy of this report, with details identifying the parties removed except Ngati Porou Hauora and my expert, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

Independent advice to Commissioner

The following advice was obtained from Janet Maloney-Moni. Ms Maloney-Moni provided her advice on the erroneous understanding that [Mrs A] was transferred to a roller-bed on [Day 2]:

> "It is with the deepest respect that I wish to acknowledge the whānau of [Mrs A]. I wish to express my sympathy in this time of sadness with the loss of their dear mum and nanny to her mokopuna.
>
> Please be advised of this report for which I have been asked to provide expert advice on to the Deputy Health and Disability Commissioner. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> The following are the list of my qualifications for both my nursing education and nursing career. My qualifications are inclusive of specialising in diabetes, heart disease, lung disease, mental health and community health care. Please note (2006) I have completed pharmacological papers to prescribe.
>
> 2006 Certificate of Proficiency (Rx), University of Auckland
>
> 2005 Master of Health Sciences (Hons), University of Auckland
>
> 2003 Nurse Practitioner Primary Health Care Māori, NZ Nursing Council
>
> 2001 Post Graduate Diploma in Health Science, University of Auckland
>
> 1998 Advanced Certificate in Coexisting Mental Health Drug and Alcohol Disorders (Completed 4 of 7papers), CIT Auckland
>
> 1995 B.Hlth Sc (Nsg) Bachelor of Health Science (Nursing), Charles Stuart University
>
> – Management and the Nurse Research, NSW Australia
> – Team Development
> – Child Health Care
> – Mental Health Nursing
> – Nursing and Communities
>
> 1995 CTT Certificate in Tertiary Teaching, Waikato University
>
> 1993 Social Psychology paper, Waikato University
>
> 1992 CAT Certificate in Adult Teaching, Waikato Polytechnic
>
> 1991 RCompN, Waikato Polytechnic

Registered Comprehensive Nurse, NZ Nursing Council

1971 Surgical Endorsement, Bay of Plenty Hospital, Whakatane

1970 EN Enrolled Nurse, Bay of Plenty Hospital, Whakatane

I have had many years of experience with providing nursing care for clients like [Mrs A] with the presenting conditions. During the years I worked within the hospital environment it was very common for clients to be admitted for this type of health care in terms of increasing mobility and investigation procedures. I have also provided this care within a home environment assisted and supported by whānau members and other health professionals i.e. Physiotherapists, Occupational Therapists, and District Nurses. There were Māori clients who preferred to remain at home cared for by their whānau members and the visiting health services. There were also Māori clients who preferred their care to be provided by whānau members within the hospital environment. My experience of working with clients diagnosed with Diabetes Type 2 have also included the complications of this condition: cellulitis, arterial venous ulcers, amputation, retinopathy, neuropathy, hyperglycaemia, hypoglycaemia, renal impairment and CVD.

All of the information provided by HDC has been read and reviewed. These include all of the patient's clinical notes, lab tests and treatment forms, letters of communication between HDC services and Ngati Porou Hauora, assessment report from Physiotherapist, Ngati Porou Hauora Policies and Procedures, Staff Roster, email to [Mrs A's] daughter and letters from Hospital Services Manager to GP, NPH CEO.

The report has mainly focused on the patient notes and the health care [Mrs A] received while in [the Hospital].

Reviewed new research information on Type 2 diabetes, obesity, types of equipment for pressure area care, wound care management, medication and side effects, and management of complex health conditions. Links to relevant websites in report.

Expert Advice Required

1. Please comment generally on the standard of care provided to [Mrs A] by Ngati Porou Hauora while she was admitted to [the Hospital] from [Day 1] to [Day 26] 2007.

The standard of care provided to [Mrs A] by Ngati Porou Hauora while she was admitted to [the Hospital] was generally good care if the 24-hour recordings are a true and accurate account of the nursing care, the allied health care and assessment and the Medical Practitioner care and assessment. Some of the recordings and signatures were difficult to read on first sighting and did require several attempts to interpret. Some of the dates are difficult to decipher but this may be related to the

papers being photocopied. There are recordings which were not chronologically correct eg record date of [Day 16] during the recordings for [Day 15].

2. Was [the Hospital] suitably equipped to care for [Mrs A]?

[The Hospital] was not suitably equipped to provide [Mrs A] with a programme to increase her mobility if the equipment needed to achieve this outcome was a hoist /lift with a lifting capacity of >140kg. They did not have this equipment during her admission.

According to the 'Patient Flowchart' the section 'Patient Activity & Safety' the box stating 'mobilizes independently' is ticked for the date of admission [Day 1]. Under the section titled 'Mobilisation' the boxes 'requires supervision and requires assistance' are ticked and according to the clinical notes [Mrs A] received this care.

The Patient Flowcharts also have these boxes ticked therefore indicating that [Mrs A] was receiving this continued care.

It is also indicated for the Patient Flowchart the section on 'Wound/Op site/Skin care' the box titled 'Skin: intact' is ticked which indicates that from the admission date [Day 1 to 13] [Mrs A's] skin integrity was being monitored with this chart. A critical aspect of care for patients with complex health conditions and reduced mobility is monitoring and recording skin integrity.

The Locum Physiotherapist report dated [Day 7] provides a comprehensive assessment of [Mrs A] and lists the strategies in place to maintain a safe environment for her and the staff. The recordings do not state that the first listed strategy:

- Ensuring the ongoing practice of having up to 3 persons for safe transfer and movement of patient from bed to sit in a bedside chair for a short period of time daily was maintained throughout her time in [Hospital]. It may not have been possible to always action this strategy effectively in terms of the staff /patient ratio within this rural hospital.

[The Hospital] was aware of the type of equipment required to ensure the safety of a client when the day following [Mrs A's] admission she was transferred [on Day 2] onto a Vendlet system bed with a Tempur Med T851-3 pressure relieving mattress.[10]

The Vendlet system bed spares the back of the carer and ensures the patient a uniform and peaceful turn — a dual function, which provides the optimum solution

[10] In fact, Mrs A was not transferred to a Vendlet system roller-bed until Day 20, and there is no evidence that she was ever nursed on a Tempur Med T851-3 (or any other type of pressure relieving mattress). Ms Maloney-Moni reviewed this part of her advice — see appendix B.

when handling bedridden patients. It enables the carer — at the touch of a button — to turn or to move a patient in and out from the middle of the bed without straining the back of the carer. The carer remains in control of the turn, making the patient feel safe and allowing support of pillows, arms, legs, and head. Utilising this bed would have assisted the staff/patient ratio safety issue.
http://www.euromedical.co. nz/el O7plugins/content/content.php?content.203

The Tempur-Med Hospital Mattress is suitable for patients with a medium to high risk of pressure sores. This mattress has been used to prevent pressure sores with great success. It is used in intensive care and on wards with long-term patients, elderly patients and patients already suffering from pressure sores.
http://www.tempur.co.nz/page781 8.aspx

3. Was it appropriate for [Hospital] to admit [Mrs A]?

According to the clinical notes the decision to admit [Mrs A] to [Hospital] was made for assessment to increase her mobility and to investigate the pain she had been experiencing in her left hip for 1 week which had no known physical cause. [Mrs A] signed the general consent form on admission and her health care commenced after admission. The documentation provides clear evidence that an initial health assessment was undertaken which included diagnostic reasoning to ascertain differential diagnoses of the left hip pain. For example, 24hrs post admission the patient was treated for a UTI [Day 2] and prescribed pharmacological intervention.

4. Was it appropriate for [Mrs A's] sons to assist with her cares while she was admitted to [the Hospital]?

Clinical note recording [Day 3] states arranged availability by sons to provide their mother with her hygiene care (showering) every 2nd day. There is no recording that this was not acceptable to [Mrs A's] sons. Discussion between sons and staff [Day 5]. This practice is common in the hospital setting for whānau who wish to support their family member while in hospital.

5. Was [Mrs A] provided with appropriate skin and wound care at [the Hospital]?

[Mrs A] was provided with appropriate skin care at [the] Hospital. Recordings for skin care in clinical notes commenced [Day 2] although a clearer description of 'good' condition is required for clarification.

Pressure area care (PAC) is recorded [Day 4], [Day 5], which is indicative of appropriate skin care being provided. If there were no recordings of PAC then this is totally inappropriate and reflects extreme neglect in terms of safe patient care.

The Waterlow Risk Assessment should have been done on admission rather than after the first recording of a red sacrum [Day 12]. [Mrs A] was an at risk client in terms of her diagnosed health condition of diabetes, reduced mobility and morbid obesity.

The recordings of wound care are shown on the Patient Flowchart, Wound Assessment and Treatment Form, Clinical Notes.

Sfera,J. (2007). Information about pressure ulcers and how to treat them. http://www 993/information_about_pressure_ulcers_and Stetz, H.(2007). Effectively Managing Pressure Ulcers. http://www 0/ effectively_ managingpressureulcers.html

6. Was [Mrs A] transferred to [Hospital 2] at an appropriate time?

The health care [Mrs A] was receiving at [the Hospital] in terms of medical interventions, wound dressings, nutritional requirements and nursing care is well documented and the decision to transfer her was made at the time when it was identified that she needed additional care; a surgical review for the management of the large infected necrotic sacral pressure sore across the top of her buttocks.

7. Are there any aspects of the care provided by Ngati Porou Hauora that you consider warrant additional comment?

The documentation for the care [Mrs A] received at [the Hospital] has no clear indication that it was not provided in her best interests. There are little remarks in the clinical notes e.g. [Day 2], [Day 4] which reflect her positive response to the nursing care.

The notes also make clear statements of the staff/patient ratio and the whānau support needed as she became unwell with the effects of diarrhoea on top of her condition of diabetes. The episodes of GI upsets on her physical and psychological wellbeing reduced her energy levels, nutrition intake, wound healing and her ability to mobilise.

It is important when a patient like [Mrs A] is admitted to a health facility that the staff is fully aware of their complex health needs in terms of risk associated with long term condition management. Engage with the experts before, rather than later.

It is a reality in small rural hospitals to manage patient care on a reduced staff/patient ratio. It is a national problem trying to attract health professional staff to the small rural hospital setting. However this is not a reason or an excuse for compromising patient safety.

Rea, H., Kenealy, T, Wellingham, J., et.al. (2007). Chronic care management evolves towards integrated care in Counties Manukau, New Zealand. NZMJ 13 April, Vol 120 No 1252

Simmons D, Schaumkel J Cecil A, Scott D, Kenealy 1. (1 999). High impact of nephropathy on five year mortality rates among patients with Type 2 diabetes patients from a multi ethnic population in New Zealand. Diabetes Med; 16:926–31."

Appendix B

Further independent advice to Commissioner

Ms Janet Maloney-Moni provided further advice following clarification by Ngati Porou Hauora that [Mrs A] was not transferred to a roller bed until [Day 20]. Ms Maloney-Moni was also asked to comment further on the pressure area care provided to [Mrs A]:

"Expert Advice Required

1. **From your review of the documentation, when did Ngati Porou Hauora staff first identify that [Mrs A's] sacral pressure area was at risk?**

   According to the clinical notes on [Day 4] night duty it is recorded 'PAC[11] to sacrum discomfort.'

   This recording did not advise or order any follow-up procedure and this placed the patient into a high risk category. There is no logic to recording this type of information if it is not discussed in hand over to the staff of the morning shift given the complex health needs for this patient. There is no mention of the sacrum discomfort alert and the only reference to patient care is the full bed sponge given by the nurses.

2. **In your view, should any additional action, in relation to [Mrs A's] pressure area care, have been taken by Ngati Porou Hauora staff on the following dates:**

   a) **On or soon after admission**
   On admission [Mrs A] was assessed with the Patient Flowchart and according to that chart in terms of patient activity and safety the boxes requires assistance and supervision are checked. It is not clear what those boxes relate to as 'requires assistance' indicates a reduced ability to care for oneself. In the Specific Intervention column her weight of 140kg is recorded but no instruction as to the care of a patient who is of this size.

   Therefore in my view [Mrs A] did not receive and was not adequately assessed for her high need for PAC on admission.

   Dolynchuk,K., Keast, D., & Campbell, K., et al (2000) Best Practices for the prevention and treatment of pressure ulcers. Ostomy/ Wound Management 2000; 46(11) 38–52.

[11] PAC is an abbreviation for pressure area care.

b) [Day 4] (the clinical record states sacral 'discomfort')

The immediate response to this recording should have been for this patient to receive 2-hrly turns and PAC to treat and relieve the 'discomfort.' There are no recordings to indicate this occurred. The next recording of PAC is on [Day 5] and it includes 'PAC cares maintained, c/ sore bottom'. This appears to have been treated with analgesia? The Patient Flowchart has the word 'shower' in the PAC section. The morning record states the patient was to be 'sponged' in the afternoon but there is no recording of her having received a sponge that day. The Specific Interventions box has the word 'sponged' checked? Therefore the next check for the sacral area occurred when?

c) [Day 8] (the clinical record states 'grazed' areas on sacrum)

The clinical record states "Pt has small grazed areas from? previous fall & bruising." This is an indication that skin integrity has been altered significantly and the need for 2-hrly PAC and 2-hrly turns. This is critical for safe care as the risk for this patient is increasing.

The Patient Flowchart has the skin 'intact' box checked? The clinical note states 'Betadine to broken areas' which reflects inconsistency and inaccuracy with this patient's care and recordings.

d) [Day 16] (the clinical record states 'broken area on sacrum (dressing) applied')

There is a clinical recording on [Day 15] which states 'Betadine and Micreme to broken areas' then on [Day 16] it states 'Broken area on sacrum. Betadine applied & Allevyn adhesive.'

At this time the area should have had a consistent and clear treatment plan as the trauma to the sacrum is now 13 days old.

In light of the new information about the date [Mrs A] was transferred to the 'roller-bed', please comment on the standard of pressure area care provided to [Mrs A] from [Day 1] to [Day 16] 2007.

The standard of pressure area care provided to [Mrs A] was inadequate and severely compromised her health which placed her in a high risk position for the development of pressure sores.

The patient's health status; reduced mobility, morbid obesity, Type 2 Diabetes and her age were contributing factors to be considered on admission assessment.

The inconsistent wound care recordings and inconsistent, sometimes illegible, PAC recordings are not a clear indication of the care [Mrs A]

received ie the PAC on the Patient Flowchart has the words 'PRN' for PAC on [Day 15] and [Day 16].

The Patient Flowchart has '4/24' for PAC, has 'OBESE' for PAC with '4/24' turns alongside the word 'Other'.

The Clinical Notes with the turning plan for [Mrs A] is inconsistent and the first recording is on [Day 19] morning shift.

Reference to 'frequent turns' and the setting up of the 'turns/positions' is recorded [Day 20].

3. [Mrs A's] pressure areas were assessed using the Waterlow Scale on [Day 15]. Please comment on:

a) The accuracy of the assessment made (No numeric values were provided on the form for the section relating to 'neurological conditions' (such as diabetes)

The Waterlow Score is a risk assessment scoring system tool. The tool itself has the risk assessment scoring system on one side and the reverse side provides guidance on nursing care and types of preventative aids associated with the 3 levels of risk status, wound assessment and dressings.

The assessment made for [Mrs A] was not accurate in terms of her neurological status. The true Waterlow has Neurological Deficit in a 'Special Risk' section and includes other categories each with a score of 4–6.

The Waterlow Risk Assessment form is therefore incomplete.

b) The appropriateness of [Mrs A's] Waterlow Score being assessed for the first time on [Day 15]

In my view the delay of implementing the Waterlow Risk Assessment until [Day 15] was not acceptable or appropriate for [Mrs A]. Although the form is not an accurate reflection of the Waterlow tool it provides some information about her risk category. An accurate assessment on admission would have placed her in the very high risk score of 20+ and the necessary care aligned with this risk should have been provided.

It is therefore my conclusion after revisiting and reviewing the information with a deeper sense of enquiry I make the statement that the care given to [Mrs A] by Ngati Porou Hauora was below an acceptable standard. The departure from those standards should be viewed with severe disapproval."

Appendix C

MAHI ROHE / Case Mix Ward SKIN CARE POLICY	NGATI POROU HAUORA INC

1. **TE TUMANAKO KA EA TE MOEMOEA** (Vision)
   Ki te whakaputa oranga mo te whanau, te wairua, te hinengaro, me te tinana.

   To promote total family healthcare, spiritually, mentally, and physically.

2. **PUTAKE** (Rationale)
   Maintenance of skin integrity is an essential element of Tinana health

3. KAUPAPA / SKIN CARE POLICY.

Ngati Porou Hauora will provide the highest standard of skin integrity to all residents and patients.

4. TIKANGA WHAKAHAERE: PROCEDURES RELATING TO POLICY

Nursing Objective: Maintenance of skin integrity is an essential element of Tinana health

4.1 On admission a Waterlow risk assessment will be completed on all individuals.

4.2 The Wound assessment and treatment form is used for all wound management plans

4.3 Re assessments will be completed using the Waterlow Risk Assessment form when necessary or at least six

4.4 Regular reporting and observations will be documented in each individuals clinical record.

4.5 Planned regular relief or pressure will be.

4.6 If incontinence is an issue, effective hygiene measures will be

4.7 Good nutrition and hydration will be provided

4.8 Where appropriate, the provision of mobility and activity (passive/active) will be maintained. Aid to daily living will also be provided

4.9 Lifestyle care plans will be utilised

4.10 Staff will be trained in Skin Care at least two yearly

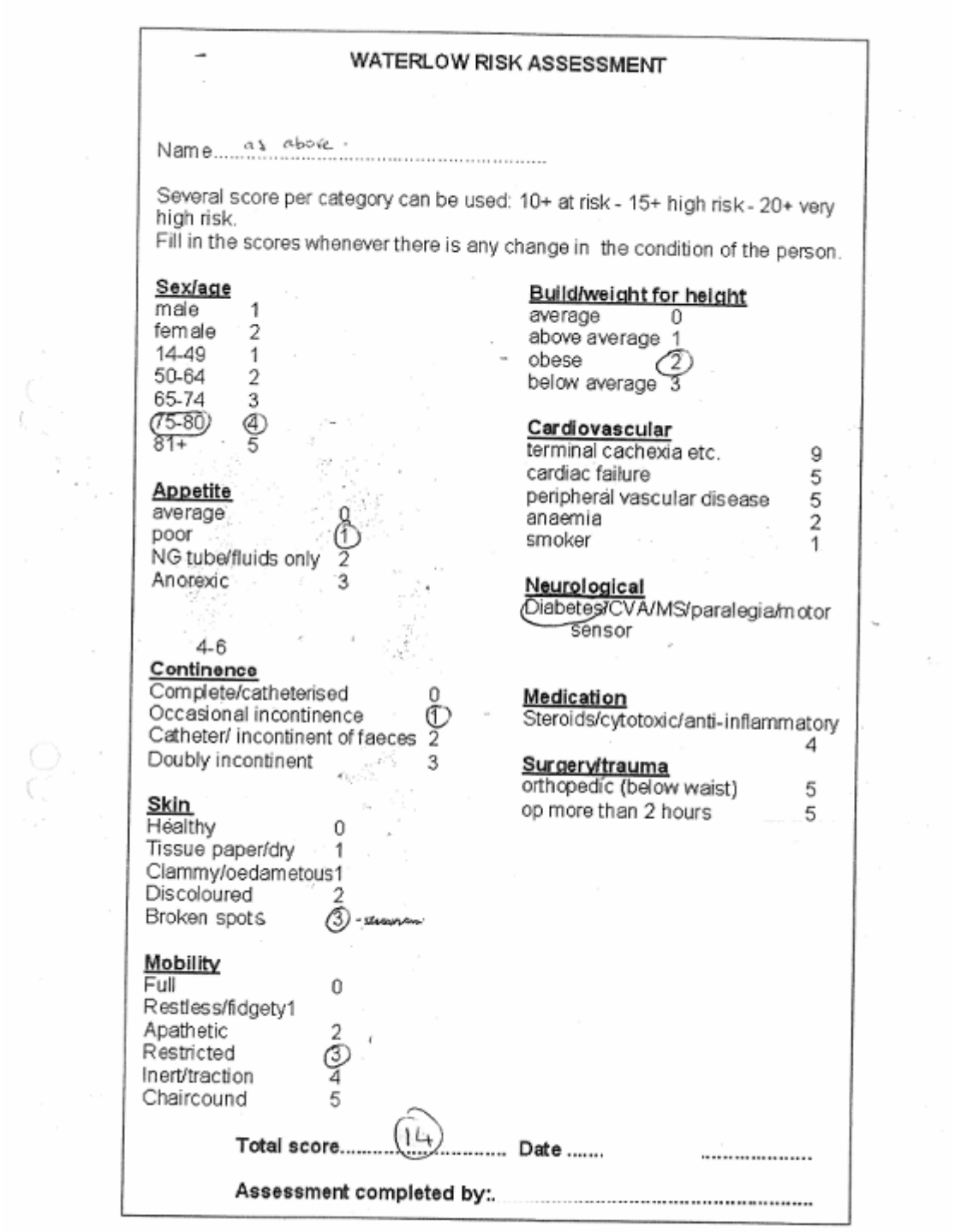
4. **NGA TURE ME NGA RIPOATA** (Legislation and Documents)
   Health & Disability Act
   Privacy Act

Date: July 2006
Updated: July 2007
Review Date: Dec 2008

1 of 2

Names have been removed (except Ngati Porou Hauora) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix D



WATERLOW RISK ASSESSMENT

Name..... as above .....

Several score per category can be used: 10+ at risk - 15+ high risk - 20+ very high risk.
Fill in the scores whenever there is any change in the condition of the person.

Sex/age
male 1
female 2
14-49 1
50-64 2
65-74 3
(75-80) (4)
81+ 5

Appetite
average 0
poor (1)
NG tube/fluids only 2
Anorexic 3

4-6

Continence
Complete/catheterised 0
Occasional incontinence (1)
Catheter/ incontinent of faeces 2
Doubly incontinent 3

Skin
Healthy 0
Tissue paper/dry 1
Clammy/oedametous 1
Discoloured 2
Broken spots (3) - sternum

Mobility
Full 0
Restless/fidgety 1
Apathetic 2
Restricted (3)
Inert/traction 4
Chaircound 5

Build/weight for height
average 0
above average 1
obese (2)
below average 3

Cardiovascular
terminal cachexia etc. 9
cardiac failure 5
peripheral vascular disease 5
anaemia 2
smoker 1

Neurological
(Diabetes/CVA/MS/paralegia/motor sensor)

Medication
Steroids/cytotoxic/anti-inflammatory 4

Surgery/trauma
orthopedic (below waist) 5
op more than 2 hours 5

Total score..... (14) **Date** ....

Assessment completed by:.....

Appendix E

WATERLOW RISK ASSESSMENT

Build Weight for Height		Skin Type Visual Risk Areas		Sex and Age		Special Risks, Tissue Malnutrition	
Average	0	Healthy	0	Male	1	e.g. Terminal cachexia	8
Above average	1	Tissue paper	1	Female	2	Cardiac failure	5
Obese	2	Dry	1	14-49	1	Periph Vascular Disease	2
Below average	3	Oedematous	1	50-64	2	Anemia	2
		Clammy (Temp)	1	65-74	3	Smoking	1
		Discolored	2	75-80	4		
		Broken/spot	3	81+	5	**Neurological Deficit**	4
						e.g. Diabetes, MS, CVA 4-6	5
						Motor/sensory paraplegia	6
Continence		**Mobility**		**Appetite**			
Complete/catheterised	0	Fully	0	Average	0	**Motor Surgery/Trauma**	
Occasion	1	Restless/Fidgety	1	Poor	1	Orthopaedic	0
Cath/incontinent of faeces	2	Apathetic	2	NG Tube/fluids	2	Below waist, spinal	1
Doubly Incont	3	Restricted	3	NBM anorexic	3	On table > 2 hours	2
		Inert/traction	4				5
		Chair-bound	5			**Medication**	
						Cytotoxics	
						High dose steroids	
						Anti-inflammatory	4

Ring score/s in the table. Several scores per category can be used. Add total.

10+ At Risk
15+ High Risk
20+ Very High Risk

Patient Name.....

NMPI.....

Date: Nov 2007
Updated: Nov 2007
Date Review Nov 2008

Names have been removed (except Ngati Porou Hauora) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.