Care Manager, Ms D

Registered Nurse, Ms E

A Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC17744)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

On 7 June 2006, Mrs A, aged 92 years, was admitted to a rest home[1] for long-term care. Mrs A suffered a degree of dementia, needed a walker to mobilise and had a high risk of falling. She had a number of falls at the rest home which resulted in skin tears. She tested positive for methicillin-resistant *Staphylococcus aureas* (MRSA) in July.

In November 2006, Mrs A's condition deteriorated, and she became sleepy and at times unresponsive. Mrs A's daughters, Mrs B and Ms C, visited regularly and discussed their concerns about their mother's care with the rest home Care Manager, Ms D. On 4 December 2006, Mrs A was reassessed as requiring hospital level care. However, on 26 December, before arrangements could be finalised to transfer her to a private hospital, Mrs A became unwell and developed pain in her left groin. An X-ray was taken, and showed no fracture.

Early in January 2007, the care staff noted that Mrs A's left leg was swollen and, the following day, Mrs A was transferred to a public hospital where she was found to have necrotising fasciitis.[2] Mrs A died in hospital shortly afterwards.

Complaint and investigation

On 8 October 2007 the Commissioner received a complaint from Mr and Mrs B and Ms C about the services a rest home provided to their mother, Mrs A. The investigation was delegated to Deputy Commissioner Rae Lamb, and the following issues were identified for investigation:

> *The appropriateness of the care provided to Mrs A by the rest home from 17 June 2006 to the day before her death in early 2007.*
>
> *The appropriateness of the care provided to Mrs A by Ms D from 17 June 2006 to the day before her death in early 2007.*

[1] In this report, references to the rest home include the owner and the previous owner.

[2] Bacterial infection of the layer of fascia (connective tissue) beneath the skin by *Staphylococcus aureas* Type A. There is tissue necrosis and toxin production causing organ shock and failure. Symptoms appear rapidly after initial infection: they include rash with blistering and discolouration of the skin, pain and inflammation of the lymph nodes, fever, drowsiness, diarrhoea and vomiting. The elderly are particularly vulnerable to the infection, which requires prompt treatment with antibiotics and excision of involved tissue.

On 16 January 2008, the period under investigation was increased to 7 June 2006 to the day before Mrs A's death in 2007. On 14 March 2008, the investigation was extended to include the following issue:

> *The appropriateness of care provided to Mrs A by Registered Nurse Ms E on the two days leading to Mrs A's death.*

The parties involved in this case are:

Mrs A	Consumer (deceased)
Mrs B	Complainant/Mrs A's daughter
Mr B	Complainant/ Mrs A's son-in-law
Ms C	Complainant/ Mrs A's daughter
A rest home	Provider
Ms D	Provider/Care Manager
Ms E	Provider/Registered nurse
Ms F	Caregiver
Ms G	Caregiver
Ms H	Director of Nursing
Dr I	Medical practitioner

Independent expert advice was obtained from a nurse with specialist knowledge in aged care, Ms Jenny Baker. Ms Baker's advice is attached as **Appendix A.**

Relevant information

The rest home
The rest home (the Home) is a 50-bed rest home and dementia care facility.

Ms D
Ms D became the Care Manager at the Home in August 2002. She registered as a general and obstetric nurse in August 1969.

Ms D's initial job description stated: "The Care Manager is the senior registered nurse for [the Home], and is responsible for managing nursing practice and delivery of care." It stated that her role included: "manag[ing] the provision of nursing care to residents (and day clients) through care staff and by appropriate nursing practice". Ms D stated that at the change of ownership, the new owner asserted that there was no change in her job description.

Ms D's job description (which was reviewed in June 2005 and was scheduled for review in June 2007) stated that one of the Care Manager's position objectives is:

> "To ensure appropriate and individualised care through assessment, planning, implementation and evaluation of care in conjunction with staff and management, whilst respecting the rights, autonomy, privacy and dignity of residents in the facility."

Two of the performance indicators state that "planned care is evaluated and reviewed at least 6 monthly and on an as required basis", and "reports individual residents changing needs to the manager to inform and seek reassessment of health and care needs if necessary".

The position description indicates that, as Care Manager, Ms D had overall responsibility for the "assessment, planning, implementation, evaluation, and maintaining of resident care".

Ms E

Ms E registered as a general and obstetric nurse in 1979 and undertook post-graduate studies in England and New Zealand. In 2002, Ms E completed a university paper, "Health and Aging". By 2006, she had been working full time, and on call as required, as a registered nurse at the Home for seven years.

Mrs A

In February 2006, Mrs A was admitted to a private hospital after she was discharged from a public hospital, following surgery to repair a fractured neck of femur. She had previously been cared for by her daughter, Mrs B.

In May 2006, Mrs B requested that her mother be assessed for long-term care. On 1 June 2006, the District Health Board Needs Assessor assessed Mrs A. The Needs Assessor noted that Mrs A needed assistance with showering, a walker to assist her with mobility for safety and to prevent falls, and redirection in the afternoons when she was confused. The Needs Assessor stated, "[Mrs A] needs to move to a rest home that will suit her needs."

Admission, 7 June 2006

On 7 June 2006, Mrs A was admitted to the Home. On admission, she was assessed by the Care Manager, Ms D. Ms D completed a "Registered Nurse Assessment", noting that Mrs A's special care issue was that she was a falls risk and that this risk was increased because she had a habit of getting up in the night to wash. Ms D noted that Mrs A mobilised with a walker, but was reasonably independent, needing only one staff member to assist her with daily living tasks. She tested Mrs A against the Folstein mini-mental state examination, and made entries into forms to monitor Mrs A's continence (fully continent), mobility (requires walker only), falls risk (high), dietary and recreation needs.

Mrs A had not appointed an Enduring Power of Attorney when she was admitted to the Home, and a note to this effect was made on her admission form: "No EPOA 12/09/06." Her daughter, Mrs B, signed as the guarantor in the admission agreement and was listed as the contact person. The Home advised that Mrs B visited her mother very regularly and was involved in day-to-day decision-making.

The nursing progress notes for Mrs A for June and early July 2006 were unable to be located.

On 13 June, the medical practitioner contracted to provide medical services to the Home's residents, Dr I, assessed Mrs A. He noted that her medical history included hip and arm fractures in 2002 and 2006 resulting from falls, a left shoulder tendon tear, hearing loss, and dementia. Mrs A also had osteoporosis with a resulting kyphosis.[3] Mrs A's extreme spinal curvature meant that she had difficulty seeing when walking, and eating was slow and difficult.

Although Mrs A was prescribed a once-daily dose of lactulose for bowel management, it was not administered regularly and, on 15 August 2006, Metamucil was added to her non-regular medication chart. However, it was not prescribed by Dr I and there is no record that it was ever administered to Mrs A. Ms D advised that "it was the general practice that the caregivers would give [lactulose and Metamucil] to the resident with their breakfast. Despite constantly being told that they needed to sign that the medication was being given the caregivers were bad at doing so, therefore the fact that this is not documented does not mean that it wasn't given".

On 18 August 2006, Mrs A was assessed as requiring all her meals to be puréed. Although this was recorded in her progress notes, her lifestyle plan was not updated.

Wound management

On 4 July Dr I recorded in the medical notes that he rechecked "wounds" on Mrs A's legs and, although "generally improving", her legs were "still inflamed". He requested a laboratory test of a wound swab from Mrs A's lower left leg. There are no nursing records relating to these lesions. Dr I's clinical records show that on 13 July, he was notified that a wound swab from Mrs A's left lower leg (presumably taken on 4 July) tested positive for methicillin-resistant *Staphylococcus aureas* (MRSA).[4]

On 23 July, Mrs A was found on the floor of her room under the hand basin at 3.34am with cuts and bruising to her nose and forehead. An "Unwanted Event" form was completed, and a "Wound Care Plan and Management" sheet was started to instruct staff on dressing the wounds to Mrs A's forehead and nose.

The nursing progress notes start on 24 July 2006 and note that Ms D had redressed the wounds to Mrs A's forehead. She documented that other staff should dress Mrs A's facial bruising "as per the Dressing Folder".

On 25 July, Dr I recorded that he saw Mrs A in relation to the fall of 23 July.

[3] Excessive outward curvature of the spine, causing hunching of the back. This can be caused by collapse of the vertebrae from senile osteoporosis, bad posture or muscle weakness.

[4] An increasingly common dangerous bacterium that is resistant to many antibiotics and is responsible for outbreaks of infections in hospitals and care facilities.

MRSA

During his visit on 25 July, Dr I recorded on Mrs A's medication prescription form an order for the broad-spectrum antibacterial co-trimoxazole to be given for 28 days. The "Non-packaged/PRN[5] Medication Administration Record" shows that Mrs A was first given co-trimoxazole on 19 July 2006. Dr I's notes indicate that co-trimoxazole was prescribed for Mrs A by a colleague on 19 July. However, because the nursing records prior to 24 July are missing, there is no record of how this medication order was generated. There is no notation on the medication charts of a telephone order for this medication.[6]

On 1 August the nursing notes record that Dr I "had prescribed co-trimoxazole to start tonight for leg ulcer". There is no mention that Mrs A was MRSA positive in the nursing notes or that any changes were made to her care plan in light of the infection. However, management of Mrs A's MRSA-positive leg wounds were discussed at monthly Infection Control Group meetings, so it appears that care staff were aware that she was MRSA-positive.

Restraint

In August 2006, staff became concerned about Mrs A getting out of bed at night to wash herself. This was a concern because of her propensity to fall, and she refused to wear hip-protectors. Ms D completed a "Restraint Minimisation Assessment" form, noting that Mrs A had had four falls in a week, and that most of the falls occurred when she got out of bed. Ms D recorded that health problems were a possible cause of the falls. She organised for Mrs A to have blood and urine tests. One of the blood tests was to assess Mrs A's heart medication (digoxin) levels.

On 9 August 2006, Ms D discussed with Mrs B the need to provide her mother with cot-sides when she was in bed, to prevent her from falling. Mrs B consented to this and signed the consent form. This was co-signed on 16 August by Dr I. The same day, the section that indicates refusal for consent to restraint was also signed. Although the Home advised that the signature was from Mrs A's other daughter, Ms C advised that she did not object to the use of cot-sides, but "did object the cuffs being used as they distressed my mother, and they seemed to be more for the convenience of the staff ..."

On 9 August 2006, an entry in Mrs A's progress notes states that restraints (cot-sides) were put in place "with [Mrs B's] consent" Ms D noted the change in Mrs A's management in her "Lifestyle Plan". An unsigned annotation to the plan, dated 15 August 2006, noted, "Bed rail restraint at night, supervise toileting closely. Do not leave the room."

On 10 August, Dr I reduced Mrs A's digoxin medication in response to the blood test results.

[5] As required.
[6] It is likely that the colleague telephoned the prescription, which is acceptable practice.

Leg wounds

The first nursing record of any wounds to Mrs A's legs (apart from the brief note about the co-trimoxazole) was on 7 August 2006, when the management of the skin tear to her right leg was recorded on the "Wound Care Plan and Management" sheet.[7] The next entry was on 15 August. This records that dressings were applied to a skin tear on Mrs A's left leg, although there is no record of how this skin tear occurred.

A "Wound Assessment and Monitoring" form shows that Mrs A's wounds were assessed monthly. However, the form is incomplete, and does not indicate the location, origin or initial assessment date of the wounds being monitored.

On 31 August, Ms D recorded that Mrs A's leg wounds were "not so good", and noted an action plan in the progress notes to elevate Mrs A's legs, dress the wounds daily and then apply pressure stockings. Ms D also noted that Mrs A's bottom was "looking worse" and advised the staff on positioning Mrs A to reduce pressure, and to apply zinc ointment to the pressure area.

The progress notes for Mrs A for September and October 2006 show that staff continued to manage the wounds on Mrs A's legs as directed.

Mrs B advised that her mother had very fragile skin that required careful monitoring, particularly on her legs. Prior to her admission to the Home, a district nurse and Mrs B had tended to Mrs A's legs to prevent tearing, bruising and ulceration. Mrs B believes that the Home did not provide appropriate care for her mother's legs, even after she had explicitly set out the necessary care in a letter delivered to the Home via facsimile. Mrs B stated:

> "I believe the infection could have been avoided had proper care been taken, especially after written advice had been offered."

November 2006

On 4 November, staff observed that Mrs A's gait was unsteady. A note was made for staff to watch her. On 8 November, Dr I reviewed Mrs A and instructed staff to reduce her antipsychotic, Risperidone, from 1½ tablets daily to one tablet. When Dr I saw Mrs A again the next week, he found that the reduction in the Risperidone had made little change. She remained drowsy.

Mrs B stated that over the next two weeks, her mother displayed "unnaturally excessive weakness and tiredness".

Mrs A's mental state changed, and she became agitated. A "Challenging Behaviour Monitoring" form was started, which recorded that she was frequently yelling out and ringing the call-bell, although she did not require assistance. Mrs A had a number of minor falls, and

[7] An "Unwanted Event" form completed on 7 August records a fall that resulted in a skin tear, but does not specify the location of the wound.

her kyphosis became more marked. On 9 November, she fell on her way to the dining room and complained of a sore hip. She was taken back to her room and given Panadol for the pain.

On 14 November, Mrs A told Dr I that she had pain in her right shoulder and her neck when she lifted her head. He prescribed her Panadol at a dosage of two tablets, three times a day. This medication was added to her Medico Pak[8] medication administration sheet supplied by the pharmacy, and she was given the Panadol as prescribed from 19 November.

Mrs A was also assessed by a physiotherapist on 14 November. The physiotherapist noted increasing kyphosis, frailty and mobility impairment. He recommended that staff trial Mrs A on wearing a collar during the day, to improve her posture. This assessment was recorded in a Short Term Problem Management Sheet on 22 November but not in Mrs A's Lifestyle Plan. Her Mobility Plan (stating that she could mobilise independently) was not updated to reflect her increasing needs.

On 22 November, Mrs A had a chest and neck X-ray, and a mid-stream urine specimen was sent to the laboratory for testing. The urine test result showed no evidence of a urinary tract infection, and the neck X-ray showed degenerative changes to the vertebral bodies and the spinal discs. The chest X-ray report was not provided.

Ms D completed a short-tem care plan to manage the hyperflexion of Mrs A's head, instructing that she be returned to bed after morning tea and again after lunch for a sleep. Mrs A was also to be turned twice daily.

Mrs B stated:

> "During conversations with [Ms D] concerning Mum's general wellbeing [Ms D] seemed unnecessarily defensive and uncommunicative in her replies. It appeared that she thought we were questioning her judgement regarding the action she was taking or had taken with Mum."

Mrs B said that at times she considered that Ms D's attitude was "unapproachable and arrogant", and was the result of her dissatisfaction with her job. Mrs B said that she "resorted to subservience when dealing with [Ms D] in an endeavour to ensure my mother's continuing welfare".

Ms D stated that she has always maintained a professional stance in her nursing practice, which includes an approachable attitude, sensitivity and empathy towards families. She said she was "very pressured" at this time because she was doing two jobs with less paid time,

[8] Medico Pak is a service offered by dispensing pharmacies, whereby an individual's medications are grouped into individual packages according to the time that they must be taken (e.g., morning, noon, night).

and could not spend the time with the residents that she had previously been able to. Ms D stated, "I am surprised that [Mrs B] felt subservient in my presence, but surely [I] am not culpable for her own sense of inadequacy."

Ms D stated:

> "The … assertion that [Mrs A] was in pain for any extended time while in my care [is] simply untrue. It is true that she was sleepy, but she was comfortably sleepy, taking naps throughout the day at any time, as she had since her admission. In my memory, she received pain relief as it was required. In retrospect, it may have helped the family to adjust if we had emphasised the increasingly palliative nature of our care."

December 2006

On 29 November 2006, the District Health Board Gerontology Nurse Specialist visited the Home to reassess Mrs A. She noted that Mrs A required a lot of time and attention to be safely cared for and that the Home "is not able to meet her needs adequately although they are doing their best". On 11 December, the Gerontology Nurse Specialist reported her reassessment and noted that Mrs A required hospital-level care, as she had developed additional care needs in relation to bladder and bowel incontinence,[9] and feeding difficulties related to her increasing cervical kyphosis.

Ms D and Mrs B discussed private hospitals for Mrs A, but Mrs B felt frustrated by Ms D's lack of "constructive contribution to the situation". Ms D stated: "I never recommend individual facilities of which I do not have first-hand knowledge". Mrs B understood that her mother could stay at the Home until a suitable private hospital had a vacancy. Ms D noted: "The family seemed reluctant to pursue the need for appropriate placement and took some weeks to find a suitable facility."

Throughout December 2006, Mrs A continued to have numerous falls, which resulted in skin tears and abrasions. Mrs B stated that from late December, her mother favoured her left leg and had pain and swelling in her left groin.

In mid-December, Mrs B and Ms C attempted to liaise with staff to obtain additional pain relief, at Mrs A's request. Mrs B said that staff generally advised that further Panadol could not be given, and that on one occasion, Ms E said that she would note on the file that stronger pain relief could be prescribed.

[9] Mrs B stated that she had never been informed that her mother was incontinent, and her family had not noted any incontinence despite regularly taking Mrs A out for long periods of time. Mrs B did note, however, that "when cot-sides were used to lessen the chance of falls, staff tried to persuade mother to wear incontinency underwear [and] this distressed her".

There are no entries in Mrs A's notes to indicate that staff were approached by Mrs B and Ms C, nor did Ms E document in Mrs A's notes that stronger pain relief was needed. Ms E does not recall this issue being raised.

Ms D advised that it was not brought to her attention, and she does not accept that Mrs A had a sore leg during the three weeks prior to her death. She disputes the claim that Mrs A had pain and swelling in her left leg from late December.

Mrs A's family spent time with her over Christmas, and became concerned about her condition. Shortly after Christmas, Mrs B asked Ms D to arrange for her mother to have blood and urine tests taken, and Ms D agreed to arrange this.

On 27 December it is recorded in the progress notes that Mrs A complained of pain in her left leg. She was given Panadol, and Dr I saw her the following day. Although Ms D stated that she attached a note to the front of Mrs A's file requesting blood and urine tests, Dr I does not recall receiving this note, and the tests were not ordered. Dr I considered that Mrs A might have a fractured pelvis, and she was taken for a pelvic X-ray.

On 30 December, the radiological report stated that no fracture could be seen, although there was significant faecal loading. A Microlax enema was administered to Mrs A and, as no result was achieved in two hours, a Fleet enema was administered, with a "fairly large result" reported in the progress notes. Neither enema was recorded in Mrs A's medication chart.

Around this time, Mrs B's husband asked Ms D about Mrs A's blood test results, and Ms D told him that she assumed them to be negative as she had not received any instructions about treatment from Dr I. Ms D advised that when she realised that the blood and urine tests had not been ordered, she intended to follow up, but this was overtaken by subsequent events.

Over the next few days, Mrs A's behaviour was monitored as she became increasingly agitated, calling out frequently, especially at night.

Early 2007

At 4.15pm on a Friday in early 2007, Mrs A was found on the floor of her room by caregiver, Ms G. Ms G checked Mrs A for injuries, found she was able to weight bear, and assisted her back to bed. The fall had reopened a healed skin tear on Mrs A's elbow, which was redressed. Ms G put up the cot-sides and filled in an Unwanted Event form. Mrs A was unsettled that night.

The duty roster indicates that Ms E was the on-call RN for the following days, Saturday and Sunday. However, Ms E is certain that she did not receive a telephone call from rest home staff Saturday or Sunday. She stated:

> "On [Saturday evening], family guests ... took us out to dinner. Normal practice on such occasions is to arrange for another Registered Nurse to cover the on-call duty for the period in question. I would have arranged for the Acting Manager (who was the Care Manager [Ms D]) to cover my on-call for the evening."

Ms D was not rostered on to work over the weekend and she denies receiving a telephone call from staff at the Home, or Ms E, on Saturday or Sunday. There is no record in the roster of any change, although such changes are recorded on other occasions.

On Saturday afternoon, when Ms G and an unidentified caregiver changed Mrs A's wet bed, they noticed that her left thigh was swollen. Ms G recorded that she reported Mrs A's condition to the "RN (Manager)", who advised that she would come in the next morning and would check Mrs A then. The staff gave Mrs A Panadol and settled her for the night.

The night shift caregiver on Saturday, Ms F, noted that Mrs A's left leg was swollen, tender, warm and painful from femur to knee. Ms F noted that, in the early morning, she contacted the on-call nurse, "Ms E", to request that she "please come in early because [Mrs A] may need to see a doctor". Ms F washed Mrs A and redressed her and settled her supported on her left side. Mrs A was noted to be "unusually quiet overnight".

Review of the telephone records for the Home for Saturday and Sunday show that no call was made to any of the registered nurses or managers — including Ms E — from the Home. Ms G does not recall whom she contacted. Ms F recalls that she spoke with Ms E.

The clinical record shows that Ms E reviewed Mrs A on Sunday morning, and noted that her left leg was swollen above the knee and she seemed to be in pain. Ms E recorded, "Not in this condition yesterday & was walking with a frame. Ambulance called, Family notified."

Mrs A was transferred to the public hospital at 12.20pm.

The Public Hospital

At the Emergency Department, Mrs A was initially seen by the Emergency Medicine Registrar, who noted that she appeared unwell, with a swollen and painful left thigh. She was started on IV antibiotics, and a left thigh/hip X-ray was performed.

The X-ray did not reveal a fracture, and Mrs A was assessed by the General Medical Registrar, who noted that she had blotchy discolouration of the outer part (lateral aspect) of her left leg, and considered that Mrs A was suffering from necrotising fasciitis. Mrs A was referred to the General Surgery team and seen by the surgical registrar, who recorded his observation that she was "clearly septic".

At 6pm on Sunday, the surgical registrar noted:

> "The only way to confirm this is OT [operating theatre]. This would be inappropriate as she would be extremely unlikely to survive this and treatment to attempt would be

> aggressive and excessively disfiguring with extremity's essentially no likelihood of a positive outcome.
>
> I have discussed this with [the consultant surgeon], who agrees with above. I have had a full and frank discussion with [Mrs A's] daughters who are in agreement with above."

Mrs A was kept comfortable and died at 9.30pm the following day.

Response to complaint

Ms D said that staff did not report to her an increase in Mrs A's levels of pain or swelling of the affected leg in the three weeks prior to her death, nor did Ms D "remark them myself" despite Mrs A being under close observation. Ms D denies that the family spoke to her about their concerns about Mrs A's left leg. She stated: "We cared for Mrs A with respect, kindness and infinite patience and close attention to detail. I was proud of the efforts of the staff to this end. In my care I deny that she was ever left for any length of time in pain or discomfort. Her physical needs were attended to meticulously and as soon as possible."

Staffing

Ms D believes that, after ownership of the Home changed, staffing levels were cut to unacceptably low levels. Ms D agreed to accept a three-month trial of reduced hours (from 40 hours to 32 hours per week) for her position as Care Manager, and found this to be unacceptable. On 31 August 2006, Ms D prepared a report for the management to evaluate the effectiveness of reduced hours. She stated:

> "The primary objective of the reduction in hours as I understand it is to reduce expenses over the entire operation in line with [rest home] policy ... in my opinion the focus has shifted from patient/resident need to the need to make a profit.
>
> ...
>
> [The rest home] has cut the Registered Nurse staffing ratio below the hours recommended by the New Zealand Standards recommendation."

In response, the Home provided copies of its *Staffing Resources Policy* and advised that its staffing levels are higher than that required by the DHB Age Related Residential Care Services Agreement, and recommended by Standards New Zealand. The Home was satisfied that the reduced hours for the Care Manager position maintained an optimal balance between safe service and resource constraints.

Subsequent changes
Following Mrs A's death, the Home implemented the owner's generic policies and resident well-being programme. It advised that staff training and education has "increased considerably" and an experienced registered nurse has been employed to replace Ms D as Clinical Coordinator. Specific changes made at the Home include the following:

- An improved archiving system (which includes keeping bowel records together with residents' other notes) has been implemented throughout the organisation.
- A nutrition and hydration policy and guideline has been developed, which emphasises recognition and treatment of weight loss.
- Pain management is now specifically included in the Lifestyle Plan.
- The infection control programme has been reviewed, and further clarity inserted into the section dealing with MRSA.
- Significant effort has been put into staff education and training at the Home, with many training sessions available for staff to attend.

Ms E advised that at the Home "there is now a daily handover meeting of Registered Nurse and Caregivers at 8.30am.

Response 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:

The rest home
The Home wrote to Mrs A's family and stated that it agrees with the finding that the overall care provided to Mrs A was not of a reasonable standard. It stated:

> "We would like to take this opportunity to again apologise for the distress caused both to [Mrs A] and you as a result of failures by [the] Home to provide adequate care. We sincerely regret that this occurred."

In response to the provisional opinion, the owner noted that the Home had undergone a change of ownership shortly before Mrs A's admission and, throughout her time there, an integration process was taking place (whereby all policies and procedures were reviewed, and staff were appropriately trained and monitored for compliance). The Home noted that "whilst this does not excuse failures to comply with correct procedures and policies, it does provide some context". The Home stated that:

> "During [that] time, a lot of effort was being put into the integration of [the Home's] quality management systems. However, [the Home] experienced resistance to change from some of these staff. The failure by staff to follow through with policies such as pain assessment and management, was unacceptable and performance management processes were commenced with the staff members involved in response to identified deficiencies in performance."

Ms D

Ms D's lawyer stated that Ms D "provided Mrs A with the best care that she was able to given the pressure of work that she was under, the reduced staffing hours, the nature of Mrs A's illness and her increasing requirements for more concentrated care.

...

[She] acted professionally and appropriately in her care of Mrs A and her dealings with her family ... any omissions were not due to a lack of concern or desire to provide the best possible care for the residents but were due to the working environment and the inability to do everything expected because of it."

Ms D's lawyer emphasised that Ms D's hours had been cut from 40 to 32 hours a week for a period, and that Ms D was responsible for 50 residents and frequently worked late to ensure residents received appropriate care. She stated:

> "[D]etailed documentation was difficult to achieve ... [Ms D] was working under a system that she felt was not coping and she tried to maintain the standards that she always applied to her work and that she had maintained under the previous owners. She made two complaints to management about the workload and the difficulty working with reduced staff levels as she felt that it was her duty to do so as the registered nurse. However, the complaints were not received well and she was told that the staffing levels were within the guidelines. Subsequently, her working environment became less supportive and more hostile."

Ms D accepted that she should have ensured that the blood and urine tests requested by Mrs B were conducted, but because her increased workload removed her from many clinical duties, she was not able to devote her "usual attention to the job of registered nurse" and was "trying to manage two jobs and was not working in [her] usual capacity".

Ms D left the Home in early 2007, and advised that she now manages a much smaller facility, which has allowed her to complete further education in care of the elderly (gerontology) and make significant improvements to her practice.

Mrs A's family
Mrs B noted, on behalf of her family, that they were "shocked by the extent of the inefficiencies, confusion and total lack of accountability ... but in retrospect not surprised".

Mrs B found Ms D's explanation as to why her request for blood and urine tests was not brought to Dr I's attention, and her reasons for failing to follow up on the test results, "unsatisfactory and unacceptable".

While Mrs A's family were grateful for the Home's letter of apology, Mrs B wrote to the Home noting that "nothing can ever compensate for the legacy of having failed a much-loved mother by placing our trust in the [Home] which [under the previous owner] had such a brilliant reputation for all round care". She noted that "the nearest we will ever come to closure is when we are assured that the staff concerned are prevented from ... working with elderly, frail and dependent people". They wished for a record of the poor care to be kept on staff member's personal files.

Ms C supported her sister's comments and expressed her dismay that "any concerns or questions I raised were effectively ignored and I was treated like a nuisance". She challenged Ms D's claim that her mother's needs were "attended to meticulously" and with "respect, kindness and infinite patience...", instead noting, "I feel that the standard of care was appalling and neglectful."

Relevant Rights and Policies

The rest home policies and Code of Health and Disability Services Consumers' Rights, which are referred to in the following opinion, are attached as **Appendix B**.

Opinion: Breach — The rest home

I acknowledge that extensive and appropriate changes have taken place at the Home since Mrs A's death over two years ago. The Home has also apologised to Mrs A's family and taken full responsibility for the poor standard of care that was provided to Mrs A during her admission to the Home. This it to their credit.

I also acknowledge that during her time at the Home, Mrs A deteriorated significantly, with increasing dementia and frailty. She required very high level rest home care. In some ways, the Home met needs that were often more than could be reasonably expected of rest home level care. As my expert, Ms Baker, has highlighted, in many respects Mrs A was provided with generally adequate care.

Nevertheless, staff at the Home were expected to follow policies when delivering care to residents, and the Home was required to comply with the terms of the Age Related Residential Care Services Agreement with the DHB. It is clear that the policies and terms were not always followed, and I am not satisfied that the Home took sufficient action to ensure that this occurred.

There were many occasions where staff did not follow appropriate policies and procedures and, although none of these instances are particularly striking in isolation, when viewed in their entirety they show that Mrs A did not receive a reasonable standard of overall care.

Care planning and needs assessment
The Age Related Residential Care Services Agreement and the Home's Policy for Resident Admission and Orientation state that a short-term care plan must be completed at the time of each patient's admission. One was not completed for Mrs A.

Although a detailed Registered Nurse Assessment and Lifestyle Plan (long-term care plan) were appropriately completed shortly after Mrs A's admission to the Home, the lifestyle plan was not updated at several key points:

- On 18 August 2006, Mrs A was assessed as requiring all her meals to be puréed. Although this was recorded in her progress notes, her lifestyle plan was not updated.

- On 14 November, Mrs A was assessed by a physiotherapist, who noted increasing kyphosis, frailty and mobility impairment. This assessment was recorded only in a Short Term Problem Management Sheet on 22 November. This long-term deterioration ought to have been documented in Mrs A's Lifestyle Plan, and her Mobility Assessment (stating that she could mobilise independently) should have been updated to reflect her increasing needs.

- On 11 December, Mrs A was reassessed by the DHB's Home and Older Adults Service, and deemed to require hospital level care. Additional care needs were

identified in relation to bowel and bladder incontinence and feeding difficulties related to increasing cervical kyphosis. However, staff at the Home failed to update Mrs A's Lifestyle Plan accordingly.

In response to my provisional findings, Ms D noted that "the progress notes were used to document any changes in a resident's care, rather than the care plans or lifestyle plans, because that is what the caregivers would look at and read (despite being told that they needed to read the other documents)".

However, the Home was required by the Age Related Residential Care Services Agreement to reassess Mrs A's needs and abilities and update her Lifestyle Plan accordingly. Furthermore, Ms Baker advised:

> "[The rest home] should have requested a reassessment of [Mrs A's] care level earlier given her deterioration with her dementia and related behaviours which were clearly impacting on other residents and demanding more than normal amount of input and supervision from staff
>
> ...
>
> the delay in requesting reassessments and the lack of assessment and evaluation of the Lifestyle Plan would be viewed with slight disapproval".

Documentation

Entries were made in Mrs A's progress notes most days, and the frequency of documentation increased as she deteriorated. However, once again, this did not meet the Home's obligations under the Age Related Residential Care Services Agreement that every caregiver and registered nurse must maintain a written record of progress for each resident under their care. My expert, Jenny Baker, noted:

> "In view of the challenging behaviour that [Mrs A] demonstrated and her deterioration in her health and abilities, I would have expected more frequent, i.e. each shift, documentation in order to clearly record [Mrs A's] behaviour and needs. A Challenging Behaviour Monitoring Form was commenced ... however, it would have been more appropriate to have commenced this form earlier and/or documented more fully within the progress notes."

Mrs A suffered many falls during her time at the Home, and these were not always documented in her progress notes or reported in incident forms, despite the Policy for Unwanted Events requiring all falls to be recorded in an incident report. Of the 19 falls Mrs A suffered, 17 were documented in Unwanted Event Reporting Forms (11 of these falls were not recorded in the progress notes), and eight were reported in the progress notes (two of these falls were not documented in Unwanted Event Reporting Forms). Furthermore (and of even greater concern), only four of the falls were notified to Mrs B. Reporting,

documentation, and notification of Mrs A's falls were poor, and did not comply with the Policy for Unwanted Events.

It is also unacceptable that Mrs A's progress notes for 7 June to 24 July 2006 (and her complete bowel chart) have been misplaced and were not available for me to consider in this investigation.

Ms D noted that "documentation was often the last thing that [I] did as people and their immediate care were [my] priority in the time available and detailed documentation was difficult to achieve". She went on to state that "despite constantly being told that they needed to sign that the medication was being given the caregivers were bad at doing so, therefore the fact that this is not documented does not mean that it wasn't given".

I accept that keeping documents up to date can be difficult; however, I do not accept that it should not be a priority. Thorough documentation, particularly in relation to care planning and adjusting care to meet a resident's changing needs, is an important part of good care. It helps to ensure continuity of care by the Home's staff. Furthermore, as noted by Baragwanath J in *Patient A v Nelson–Marlborough District Health Board*,[10] "it is through the medical record that health care providers have the power to produce definitive proof of a particular matter" (in that case, that a patient had been specifically informed of a particular risk by a doctor). In my view, this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted.

Pain assessment and management

The Policy for Pain Management was in use at the Home during Mrs A's admission on 7 June 2006, but was not followed by staff who admitted and cared for her.

Although the Registered Nurse Assessment, completed on Mrs A's admission, noted that she suffered pain at night, it did not provide details about the pain. According to the Policy for Pain Management, separate pain assessment should have been conducted to assess the severity of the pain, and its onset, duration, type, aggravating and relieving factors, and treatments already tried.

Although Ms D noted that "Mrs A was monitored closely for pain control", a thorough pain assessment was never completed. Mrs A was provided with regular analgesia (paracetamol) from admission, and this was documented in the Medication Chart. However, the effectiveness of the pain relief was not assessed, and this was contrary to the Policy for Pain Management, which required at least weekly reviews.

[10] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV-2003-204-14, 15 March 2005).

On 14 November, Dr I changed Mrs A's analgesia regime from a once-daily dose to three times a day, and the amount was increased from 1000mg to 3000mg daily. The reason for this increase is not recorded by Dr I in the notes, and no additional doses were recorded prior to this. Clearly, Dr I considered Mrs A's once-daily regime to be insufficient, and I can only assume that Mrs A was in pain when Dr I assessed her. It is unacceptable that staff at the Home did not assess the adequacy of Mrs A's pain management on a regular basis, or when it was obviously inadequate.

Ms Baker advised:

> "There is no evidence of any pain assessment being conducted at any time during [Mrs A's] tenure with [the Home] nor any pain management care plan developed. In my opinion, [the Home] did not adequately assess or plan appropriate pain management or provide adequate analgesia to [Mrs A]; this would be viewed with moderate disapproval."

Bowel care

When Mrs A was admitted to the Home, she was fully continent of her bowels, although a once-daily dose (10ml with breakfast) of lactulose was prescribed for bowel management, and charted in Mrs A's regular medication chart. However, the administration record shows that lactulose was given to Mrs A very irregularly, with up to 23 days between doses.

Although regularity had been identified as a problem for Mrs A, there is no nutrition plan in her lifestyle plan to ensure that she received adequate fibre in her diet to assist her bowels and prevent constipation. On 15 August 2006, Metamucil (20mg) was added to the non-regular medication chart, although it was never signed for by Dr I, and there is no record that it was ever given to Mrs A.

In respect to my provisional findings, Ms D advised that "it was the general practice that the caregivers would give [lactulose and Metamucil] to the resident with their breakfast. Despite constantly being told that they needed to sign that the medication was being given the caregivers were bad at doing so, therefore the fact that this is not documented does not mean that it wasn't given." Equally, the Home has advised that the absence of Mrs A's bowel chart, while unacceptable, does not mean that the care was inadequate.

However, I accept Ms Baker's advice that Mrs A's bowels were not well managed. On 30 December 2006, the radiological report from an X-ray taken two days previously noted faecal loading, and a Microlax enema was administered. As no result was achieved after two hours, a Fleet enema was administered, with a "fairly large result" reported in Mrs A's progress notes. Neither the Microlax, nor Fleet enema was recorded in Mrs A's medication chart, although another Fleet enema, given four days before she died, was recorded in the medication chart.

Throughout her time at the Home, Mrs A's bowel care was not always of an acceptable standard. Medications were either not administered or not charted as given (it is impossible to know which), and there was clearly a lack of prevention measures in terms of nutrition planning. Mrs A's Bowel Chart could not be located, so it is impossible to know whether staff accurately monitored her bowel motions in order to manage any constipation in a timely manner.

Wound care

Mrs A was generally provided with good wound care while at the Home. Ms Baker noted:

> "Appropriate wound products for management of infected wounds were used; tape was not used to secure dressings when it was identified that [Mrs A's] skin tore on removal of the tape, wounds were dressed at regular intervals and swabs were taken of the wounds with antibiotics prescribed by the GP."

However, although Mrs A's wounds were frequently reassessed (this is evidenced by the changing wound products used), a Wound Care Plan and Management Sheet was not always completed, and the entries that were made were often difficult to follow. On occasion, wound care assessments were not attributable to a staff member, important details were incomplete, or the Sheet referred to more than one wound area. Ms Baker observed:

> "There are several Wound Care and Management Sheets, none of which have the data completely filled out. Some of the wound Care Plan and Management Sheets have two wound areas documented ... [which] makes it difficult to determine whether both wounds are being dressed with the same products or which wound they are referring to when documenting."

In her response to the provisional opinion, Ms D noted that instructions for wound care were "understood by staff involved", but that it was not possible to document with a lot of detail. Again, she cited a lack of time relating to reduced hours.

On 8 December 2006, a Wound Care Plan and Management Sheet was commenced for a wound to Mrs A's left knee, and Bactroban[11] was applied on five occasions between 8 and 13 December. I am concerned that a prescription-only medication was used to treat Mrs A, but was not recorded in her Medication Chart, Medication Administration Records, or Dr I's Medical Notes.

Pressure area management

Although an egg-shell mattress, cushions, Allevyn heel pads and sheepskin boots were put in place to relieve and manage Mrs A's pressure areas, they were not sufficient to prevent further deterioration, and Mrs A's heels in particular had broken down significantly by the time she was admitted to hospital. Ms Baker advised:

[11] Bactroban is a prescription-only antibiotic cream.

> "Allevyn heel pads, and sheepskin boots ... should not be necessary on an appropriate relief mattress. I believe that [Mrs A] should have been placed on a pressure relief mattress such as an alternating air mattress."

In response to my provisional findings, Ms D submitted that "[Mrs A] had not been on bedrest and therefore did not need any other precautions against pressure sores other than she had been given". I do not accept this. Mrs A was known to have fragile skin, and her pressure areas obviously deteriorated over the time she was at the Home. Although she was not on bedrest, Mrs A's condition necessitated that particularly careful attention be paid to pressure area care.

I note that the Home is contractually required to provide appropriate equipment as per the DHB Aged Care Residential Agreement, which states:

> "D15.3 Facilities and Equipment
>
> a. You must provide communal aids and equipment for the personal care or the general mobility needs of substandard Residents who require them, including (but not limited to) ... pressure relief (including mattresses, heel protectors and seat cushions)."

Mrs A's fluctuating, but overall weight loss is discussed in greater detail in the next section, but is also relevant to managing her wound care. Ms Baker advised that excellent nutrition and weight management is necessary for effective wound management. The Home staff ought to have recognised that Mrs A's poor appetite and fluctuating weight may have slowed wound healing and increased the risk of infection and skin breakdown on pressure areas.

Although the standard of wound care provided to Mrs A was generally adequate, Ms Baker advised:

> " ... [T]he documentation, lack of nutritional review and good management and the standard of the pressure relief mattress and cushion would be viewed with slight disapproval."

Assessment and observation

On admission to the Home on 7 June 2006, Mrs A's temperature, pulse, respirations, blood pressure and weight were recorded on the Medical Profile on Admission form. Although the form also provided a prompt for recording results of urinalysis, this was not done on admission or within 24 hours. Other assessments were not conducted regularly or as indicated, and clinical observations were not always acted upon.

Mrs A's blood pressure dropped from 124/64 on 7 June to 98/60 on 6 July, and remained low throughout October, November and December. However, these persistent low blood pressure recordings were not reported to Dr I, and there is no indication that standing and supine blood pressure recordings were taken as part of investigations into Mrs A's falls.

Mrs A's weight was recorded on her admission, and was the same a fortnight later. However, she was not weighed again until 14 October, and she had lost 1.8kg. Subsequently, Mrs A's weight was more regularly monitored, with approximately weekly recordings. Her weight continued to fluctuate and, at the last recording dated 9 December 2006, she had lost 2.7 kilograms, compared to her admission weight. Ms Baker advised:

> "[O]f concern is that the ongoing weight fluctuation and weight loss was not followed up by the Registered Nurses ... [Mrs A] did not appear to have a Dietician review during her tenure at [the Home] and it appears that the GP was not informed of the weight loss."

In response to my provisional opinion, the Home submitted that "[Mrs A's] weight loss could not have been expected, in isolation, to raise significant concern with the caregiver staff involved with her care". However, Mrs A's weight fluctuation was not in isolation — she was on a nutritional supplement and had a poor appetite. Mrs A's weight was a known concern and was appropriately being regularly recorded. I accept my expert's advice that the Home should have acted on the fluctuating, but downwards, trend.

Mrs A's temperature and pulse were not recorded on 13 July 2006, when swabs were taken from wounds on her left leg, which were suspected to be infected.

On 21 November 2006, the Home referred Mrs A for a needs assessment review and she was subsequently assessed as requiring hospital level care. Given Mrs A's increasing dementia and general deterioration, a review should have been requested earlier.

Summary

In my view, the inaction and failure to follow policies and meet contractual requirements by so many staff, over many months, is unacceptable. I acknowledge that this occurred at a time of change, following the purchase of the facility. I also accept that there were difficulties integrating new policies, procedures, and systems. It was a difficult time for staff, and there may have been some resistance to change. This does not excuse the Home (and its owners) from their duty to ensure that residents were well cared for during such a transition period.

Mrs A was entitled to have services provided that complied with legal, professional, ethical and other relevant standards, including policies and contractual obligations concerning quality of care. In my view, the Home failed to comply with its own policies and its contractual obligations in the DHB Aged Care Residential Agreement, as discussed above. In my opinion, the Home failed to provide Mrs A with services with reasonable care and skill. Accordingly, the Home breached Rights 4(1) and (2) of the Code.

Opinion: Breach — Ms D

Care and Coordination — December 2006
On 27 December 2006, Mrs A's daughter, Mrs B, requested blood and urine tests be done for her mother. Ms D agreed, and arranged for Dr I to assess Mrs A the following day.

Ms D advised that it was her usual practice to write such a request in the daily diary or separate doctor's book (which lists those patients needing to be seen by the doctor and what they need to be seen for). However, the request for blood and urine tests was not documented for Mrs A, and Ms D stated that she "cannot explain or understand why the request for the tests was not included in the book on this occasion". She accepts that this ought to have been the case.

Ms D also advised that it was her custom to attach a note to the front of the resident's medical chart with any queries or requests for the doctor, and she did this for Mrs A's chart on 28 December 2006. She subsequently assumed that the test had been done. As Ms Baker advised:

> "[T]his practice would leave room for the note to fall off and therefore the doctor, and the attending Registered Nurse, would not be aware of the queries. I believe a safer practice would be to write out a list of queries regarding residents on a separate file note for the doctor and attending Registered Nurse to refer to."

Consequently, Dr I does not recall receiving Ms D's note, and "was unaware of any request made by Mrs A's family regarding her care". Unfortunately, Dr I was under the mistaken impression that a mid-stream urine specimen had been sent to the laboratory on 27 December and so did not order the test himself.

It is unacceptable that Dr I was not informed of Mrs B's request for blood and urine tests, and the reasons why she felt they were required for Mrs A. Dr I would have then made a clinical decision as to whether the tests were warranted and ordered them if he felt they were necessary. Ms Baker noted:

> "The Registered Nurse should have documented in the progress notes that the GP was informed of the daughter's request and his response to the request. The daughter then should have been informed by the Registered Nurse of the GP's decision … and this communication documented in the progress notes or on the Communication with Families/Friend/Agents form. The daughter should also have been informed by the Registered Nurse of the results of any blood or urine tests that the GP decided to order.
>
> …

> [Ms D's] assumption that the blood and urine tests had been attended and the results negative … implies negligence on [Ms D's] part in not following up on the family's request for the results. If [Ms D] had read [Dr I's] entry in his medical file ... she would have noted that [no blood tests had been ordered and] he assumed the MSU had been done."

Ms D was responsible for ensuring that Dr I was aware of Mrs B's request to follow up the results of any tests that were ordered, and for communicating the results and/or Dr I's decision to Mrs B.

Although it was wrong for Ms D to assume that the blood and urine tests had been ordered, and the results were fine, there is no indication that Ms D intentionally misled Mrs A's family, as alleged by Mrs B. Ms D has submitted that the omission was due to her workload (at the time, she was doing two jobs) and this led to her assumption that the tests had been done and her failure to check the records. I acknowledge that there were mitigating circumstances; however, this is not an isolated omission and, as discussed below, Ms D had substantial responsibility for the standard of care provided to Mrs A.

Care Manager's responsibility

While I have found that the Home is directly liable for the poor standard of care provided to Mrs A, as Care Manager Ms D bore a significant responsibility to ensure that a reasonable standard of care was provided to Mrs A by nurses and caregivers. In particular, I note that her job description sets out her responsibility to "ensure appropriate and individualised care through assessment, planning, implementation and evaluation of care in conjunction with staff and management". Ms D was also responsible for ensuring that residents had a "reassessment of health and care needs if necessary", and that the planned care was "evaluated and reviewed at least 6 monthly and on as required basis".

Furthermore, her earlier job description also made her overall responsibilities quite clear. Ms D would have been in no doubt what her role was in providing oversight of residents' care, particularly in relation to assessment and planning.

I acknowledge that Ms D found it difficult to maintain high standards with her increased workload and reduced staffing levels, and produced two reports to bring her concerns to the attention of management. Nevertheless, I remain of the view that Ms D must share some responsibility for the failings in the care provided to Mrs A.

Summary
In my view, and as set out in detail above in relation to the Home, the ongoing assessment and planning of Mrs A's care was inadequate. Accordingly, by failing to ensure that Mrs A received an adequate standard of care, and for failing to facilitate co-ordinated care between herself and Dr I, Ms D breached Right 4(1) and (5) of the Code.

Opinion: No Breach — Ms E

Although caregivers documented contacting Ms E on Saturday and Sunday to report Mrs A's swollen left leg, Ms E strongly denies that this occurred. She is very clear that she swapped her on-call duty for that night, and was not contacted. Ms D, however, is equally clear that she was not on call and was not contacted. This is supported by the telephone records, which indicate that no calls were made to Ms E or Ms D during the relevant period.

The roster does not clarify matters. It does not record any change to the on-call duty even though this has been recorded on some other occasions. Furthermore, some time has elapsed since these events, and while one caregiver, Ms F, recalls contacting Ms E later on Saturday, Ms G does not recall anything.

My expert noted that "the lack of appropriate follow-up … would be viewed with severe disapproval", but given the passage of time and the conflicting evidence, it is impossible to be certain if a call was made and, if so, who was responsible for following up concerns about Mrs A's condition on Saturday.

Clearly Ms E did assess Mrs A on Sunday morning, and I am concerned that she may not have assessed her immediately. Ms E started work at 8am and an ambulance was not called until 10.52am. However, there is no documentation about what time Ms E reviewed Mrs A, and I also accept that Ms E may not have been informed of Mrs A's condition at the start of her shift. I note that she has apologised to Mrs A's family, stating, "I would like to apologise that my documentation of the events … was not more thorough" and she has completed a return-to-practice course, which has increased her awareness of the need for thorough documentation. Further changes have been introduced to ensure proper handover at the start of the day shift.

The lack of clarity around this aspect of Mrs A's care is not satisfactory; however, I am unable to clarify matters further. In these circumstances, I find that the care Ms E provided to Mrs A does not justify a finding that she breached the Code.

Other Comment

Communication

A general issue raised by this case is poor interaction with Mrs A's family, who complained that they were not provided with adequate information about their mother's condition, and that their concerns were not acted upon.

Mrs B complained that Ms D failed to make herself available and approachable, or to update the family on Mrs A's condition when they became concerned about her deterioration, and that she acted unprofessionally by discussing management and staffing issues.

Ms D denied these allegations and stated that she never became aware of any problems with Mrs A's left leg. In relation to discussing management and staffing issues, Ms D advised that this discussion "had more to do with explaining and reinforcing the importance of moving [Mrs A] on to a facility equipped for the higher level of care she was due".

Mrs B also complained that she found Ms D to be "unapproachable and arrogant", and unwilling to assist with finding a private hospital for Mrs A. The tenor of Ms D's response to the complaint suggests that there is substance to Mrs B's feelings that Ms D was overly defensive and difficult to approach. Certainly, Ms D did not adequately update the family on Mrs A's deteriorating condition. I note that, in her response to the complaint, Ms D acknowledged:

> "[I]t may have helped the family to adjust if we had emphasised the increasingly palliative nature of our care."

Mrs A's family also raised concerns about communication with Ms E. They said that in mid-December 2006, they requested additional Panadol for Mrs A's pain on several occasions. On one occasion, Mrs B recalled discussing the matter with Ms E, who said that she would note on the file that stronger pain relief could be prescribed.

There is no evidence that Ms E made the relevant entry in Mrs A's notes or that she re-assessed Mrs A's pain management. I am concerned that Ms E may have given an undertaking to Mrs A's family yet failed to follow through with the necessary action, and that she did not recognise the need to either reassess Mrs A's pain management regime herself, or arrange for Dr I to do so.

Although Ms D's recollection differs from Mrs B's on a number of points, and I have been unable to verify the allegation against Ms E, it is unlikely that such complaints from a family would be made in the absence of underlying communication difficulties. Ms E has advised that she has reflected on her communication with Mrs A's family. She has appropriately recognised that it is important for families to feel listened to; to have their concerns acted on; and to receive feedback from staff.

Ms D has said that she feels "disappointed" the family found her difficult to approach. Ms D should reflect on how she could be more approachable in future.

Decision to use cot-sides/restraint
From 9 August 2006, the cot-sides on Mrs A's bed were raised at night, in an attempt to prevent falls and discourage her from getting out of bed unassisted. Mrs B consented to the use of this restraint.

However, since Mrs A was not competent to make an informed choice, and no person was entitled to consent on her behalf, Ms D should have decided whether to put cot-sides on Mrs A's bed according to the process set out in Right 7(4) of the Code.

This required her to "take into account the views" of Mrs B and Ms C, and consider whether the installation of cot-sides was in Mrs A's best interests. Although Mrs B and Ms C were interested in their mother's welfare, and it was right to take their views into account, neither was entitled to consent to the use of restraint on Mrs A's behalf.

It was misleading to ask Mrs A's family to complete consent forms regarding the use of cot-sides, and their views should have instead been recorded in the progress notes or on a form that does not refer to that person's "consent".

Recommendations

I recommend that the Home:

- Report back to me by **16 March 2009** on progress and steps being taken to improve compliance, especially with policies and procedures in relation to:
    - Managing residents at high risk of falls.
    - Preventative management strategies for residents' bowel care.
    - Referring residents for needs re-assessment.
    - Documentation, including staffing and roster changes.
    - Communication with families.

I recommend that Ms D

- Report back to me by **16 March 2009** on steps she has taken to improve communication with families.

Ms D and Ms E have reflected on their practice and provided letters of apology for forwarding to Mrs A's family.

The Home has apologised directly to Mrs A's family, and advised of changes made to address the issues identified by these events.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, HealthCert, and the District Health Board.
- A copy of this report, with details identifying the parties removed except the expert who advised on this case, will be sent to HealthCare Providers New Zealand, and the Association of Residential Care Homes, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

The following expert advice was provided by Registered Nurse Jenny Baker on 5 March 2008.

"I have been asked to provide an opinion about the standard of care that [Mrs A] received while at [the] Rest Home in relation to the following questions:

Complaint

- *The appropriateness of care provided to [Mrs A] by [the Home] from 7 June 2006 to [the day before her death in early] 2007.*
- *The appropriateness of care provided to [Mrs A] by [Ms D] from 7 June 2006 to [the day before her death in early] 2007.*

1. Please comment generally on the standard of care provided to [Mrs A] by [Ms D] and [the Home] from 7 June 2006 to [the day before her death in early] 2007.

If not answered above, please also provide the following advice:

2. Was [Mrs A] provided with appropriate analgesia throughout her stay at [the Home]?

3. Did [Mrs A] receive timely and appropriate appointments with her GP during her stay at [the Home]?

4. Was [Mrs A] provided with appropriate bowel care?

5. Was [Mrs A] provided with appropriate wound care?

6. Were [Mrs A]'s clinical observations monitored appropriately?

7. [Mrs A] did not receive blood and urine tests, as requested by her daughter, when she saw the [Dr I] on 28 December 2006. Was this appropriate? Did [Ms D] have any responsibility to follow-up this request with [Dr I]?

8. Are there any aspects of the care provided by [Ms D] or [the Home] that you consider warrant additional comment?

If, in answering any of the above questions, you believe that [Ms D] or [the Home] did not provide an appropriate standard of care, please indicate the severity of the departure from that standard.

I have been provided with one bundle of documents as follows:

- Letter of complaint from [Mr and Mrs B] and [Ms C] dated 8 August 2007.
- Notification of investigation and extension of investigation, letters to [Ms D] and [the certified person for the Home] dated 7 November 2007.
- Information from [Ms D].
- Information from [the Home]
- [Mrs A's] clinical notes from [the] DHB.

I was provided with a second bundle of documents as follows:

Further information provided by [the Home].

Professional Profile

I registered as a Registered Nurse in 1978. From 1978 to 1981 I worked as a Staff Nurse in Oncology. From 1981 until 1995 I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital. In 1995, I was Clinical Nurse Co-ordinator in an Assessment, Treatment and Rehabilitation Ward (A, T & R) before taking up the position of Unit Manager, A, T & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents. From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract, I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors. From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. From 2006 to 2007, I worked as a Care Manager in a rest home and rest home dementia. I currently work in a generalist medical ward and critical care unit for a DHB public hospital. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

Background

[Mrs A], a 92-year-old lady, was a resident of [the Home] from 7 June 2006 to [the day before her death in early] 2007. She had been assessed as requiring hospital-level care on 4 December 2006, but remained at [the Home] until a suitable private hospital had a vacancy.

Throughout late November 2006, [Mrs A's] condition deteriorated. Her daughter, [Mrs B], described this as 'unnaturally excessive weakness and tiredness'. However, [Ms D] (Care

Manager) advised: '[Mrs A's] decline was gradual but definitive over the period that she was at [the Home] ... she was sleepy, but comfortably sleepy'.

[Mrs B] noted that her mother also began to suffer persistent left leg pain around this time, and complained that she was not supplied with sufficient analgesia. [Ms D] however, denies that [Mrs A] was uncomfortable or in significant pain throughout her stay at [the Home]. [Ms D] advised that she arranged for the GP to attend [Mrs A] as soon as she became aware of her leg pain.

On [Friday], [Mrs A] suffered a fall, and although the incident report states that this was reported to the family, [Mrs A's] daughters complained that they were not informed.

On [Sunday], [the Home] transferred [Mrs A] to [the public] Hospital, as she had a high fever and suspected broken hip (from the fall two days previously).

[Mrs A] was subsequently diagnosed with necrotising fasciitis, and died on [the following day] 2007.

1. Please comment generally on the standard of care provided to [Mrs A] by [Ms D] and [the Home] from 7 June 2006 to [the day before her death in early] 2007

[Mrs A] was admitted to [the Home] on 7 June 2006. There is no nursing transfer form from the previous facility regarding [Mrs A's] identified needs in the file I was supplied with. A Registered Nurse Assessment was completed on the 9 June 2006; all parts of the assessment were completed except for 'eating'. This assessment documented the use of cot-sides, a form of restraint, *'09.08.06 cot-sides in use nocte only to prevent falls & encourage sleep'*. Cot-sides are not the preferred option to manage falls risk as they are considered a form of restraint and there is a significant risk of the resident climbing over the cot-sides which would increase the risk of serious injury to the resident. In [Mrs A's] case, a Restraint Assessment form was completed, I could not find any evidence within the progress notes of any attempt by [Mrs A] to climb over the rails, therefore the cot-sides were an acceptable option. I am not sure how the cot-sides would promote sleep as they do not stop residents from waking up. However, there is no evidence that [the Home] trialled or used a pressure mat to alert staff every time [Mrs A] attempted to get up from her bed or her chair as a precursor to using cot-sides, this would have been the preferred best practice option.

Further assessments were completed: *'Assessment of Pressure area risk using the Norton Scale, 04/06/06; Incontinence Assessment no. date; Elderly Mobility, scale, 13/07/06; Resident Mobility Assessment for Safe Handling, 13/07/06; Fall Risk Assessment For the Ambulatory rest home Resident, no date; Folstein Min-Mental-State Examination (MMSE), no date; Resident Dietary Information, 07/06/06; Recreation Assessment, 7/6/06; Restraint Consent Form, 09/06/06; Restraint Minimization Assessment Form, 09/06/06; baseline recordings of temperature, pulse,*

respirations, blood pressure & weight, 07/06/06 (recorded on the Medical Profile on Admission Form).

All assessments which were dated were completed within the timeframes specified in the Policy for Resident Admission & Orientation. There is no short term care plan in the bundle of documents provided; this care plan is required to be completed under the District Health Board (DHB) Residential Care Contract and the Policy for Resident Admissions & Orientation. The Lifestyle Plan (long term care plan) was completed on 13/07/06 as per the Policy for Resident Admissions & Orientation timeframes and those of the DHB Residential Care Contract. [Mrs A] was identified as a high falls risk and a plan of using cot-sides was implemented. Hip protectors were used as a protection against a hip fracture when [Mrs A] fell. The Registered Nurse Assessment form states: *'PAIN AND DISCOMFORT 2. Pain needs managing (2 word) round at night'*. There is no section in the Lifestyle Plan for pain. There is no evidence of a pain assessment completed.

The Restraint Consent Form was completed for *'cot-sides only when [Mrs A] is in bed'* and signed for in both the *'Consent to his/her being restrained as described above' and 'I DO NOT CONSENT to him/her being restrained and I accept the risk associated with this decision'*. The signatures are from different people and their name and relationship to the resident has not been completed. This form is confusing and therefore restraint should not occur without the form being correctly completed for either consent or no consent. It is clear that restraint and restraint monitoring was practised on [Mrs A], by the use of cot-sides as evidenced by the Restraint Monitoring Form which commenced: *'09/08/06 15.45 cot-sides' and continued until; [Sunday] 01.45 no commode & PU pad wet & changed, 05.70 F, washed & dressed in bed'*. The monitoring of the restraint, although not documented every 4 hours whilst in bed, has been documented regularly with good evidence that [Mrs A] was monitored closely during the periods of restraint.

The Registered Nurse Assessment is only a tick box form and does not have the space for the Registered Nurse (RN) to add additional comments easily. The information obtained on the assessments and her Lifestyle Plan appeared appropriate to her level of care at the time of admission and is in keeping with the Support Needs Assessment completed on 1/6/06 by [the] District Health Board staff. A 6 week Post Admission Follow up Survey was completed with [Mrs A] on the 15/09/06 to ensure that her needs were being met and what does she require: *'Are your needs being met? Yes — quite good; Do you require more or less assistance with bathing or showering? I get through alright — sometimes is a bit difficult due to R) shoulder stiffness; Do you require more or less assistance with dressing and undressing? As above; Do you require more or less assistance with mobility? Doing well with walking with (? word)'*. This survey shows resident satisfaction with her Lifestyle (Care) Plan.

The progress notes have mainly been documented in daily, although there are periods of a few days gap, by caregivers with entries by RN's at times. Daily progress notes are a minimum expectation for rest home Residents; ideally for best practice they should be

written in on each shift. In view of the challenging behaviour that [Mrs A] demonstrated and her deterioration in her health and abilities, I would have expected more frequent, i.e. each shift, documentation in order to clearly record [Mrs A's] behaviour and needs. A Challenging Behaviour Monitoring Form was commenced on 20/12/06, as discussed below in the paragraph discussing dementia, which documented [Mrs A's] behaviour, however, it would have been more appropriate to have commenced this form earlier and/or documented more fully within the progress notes.

[Mrs A's] admission weight was recorded on the Medical Profile. On Admission form. She was weighed again on 24.6 which was the same weight. Her weight was not taken again until 6/10/06 which demonstrated a loss of 1.8kgs. Subsequently, [Mrs A's] weight was more regularly monitored approximately weekly intervals with no more weights recorded after the 9/12 entry. [Mrs A's] weight fluctuated and was 39.1kgs on 9/12; a loss of 2.7kgs over 5 and ½ months, which is quite significant. Of concern, is that this ongoing weight fluctuation and weight loss was apparently not followed up by the Registered Nurses. I note that [Mrs A] was on Fortisips, a nutritional supplement once daily. [Mrs A] did not appear to have a Dietician review during her tenure at [the Home] and it appears that the GP was not informed of the weight loss. A Dietician review can be requested through the GP or [the Home] could directly request their Dietician to review [Mrs A]. [Mrs A] was entitled to have 2 to 2.5 Fortisips per day and therefore the GP or Dietician could have requested this from HealthPac for [Mrs A]. Additionally, the Dietician may have assessed [Mrs A] as benefiting from a nutritional supplement, such as Cubitan, specially formulated to assist with wound healing and may therefore have discussed this with [Mrs A's] GP or specialist in order to have it applied for from HealthPac.

[Mrs A] was assessed on 18/8/06 as requiring her meals to be [puréed] as stated in the progress notes: *'2pm to have meals [puréed]'*. The Lifestyle Plan was not updated accordingly. There is no evidence that [Mrs A] was put on a high protein diet or on finger foods. A high protein diet is essential with wound healing and dementia residents manage finger foods well. Again, a Dietician review would have ensured that [Mrs A] received an adequately nutritious diet.

The progress notes demonstrate that [Mrs A] received assistance with her ADL's (Activities of Daily Living) from the caregivers. Some examples are: *'25/7/06 7-1 All cares given; 19/8/06 [Mrs A] had a good shower also her dressing been done (both her legs and her pressure sore around coccyx area rub with Ungvita both heel; 30.8.06 Showered tonight; 12–9 [Mrs A] washed and assisted her to get dressed. Put on her stockings; 7–3 19-9-06 Assisted in all cares; 3.10.096 All cares given; 26.10 Legs moisturised each morning and elastic stocking put on; 9, 11. 11–7 Assisted her to go to commode; 22.11.06 3.11 [Mrs A] drinking heaps responding very well ringing bell for commode 2 x has passed a lot of urine; 27/11/Morning cares given; 9/12/06 All cares rendered; 19.12.06 [Mrs A] taking up a lot of our time always yelling out help me. Get her into bed then she says she thinks she wants to go to the toilet put her on commode she*

does not want go; 27.12 All morning cares given. Shouts out for help all the time needs lots of help with ADL's; [Thursday] All cares given; [Friday] 11–7 most of the time calling & yelling for help in the night. Needs attended. Wants to go to the toilet but when you put her on the commode nothing happen; [Saturday] 11–7 gave her a washed on bed & dressed'.

Prior to [Mrs A's] admission to [the Home] she was reassessed by [the] DHB NASC (Needs Assessment Service Co-ordination) on 1/06/06 on the request of her daughter: *'[Mrs A] was reassessed today at daughter's request'*. [Mrs A] was residing in a private hospital at the time and was reassessed for rest home level care: *'[Mrs A] needs to move to a rest home that will meet her needs'*. I note that the Support Needs Assessment (1/6/06) documents: *'Daughter stated [Mrs A] would never wander out on the road....; Sundowns needs some direction at times — has improved Packs clothes. Then unpacks — can be stroppy... wandering. Was going into other peoples' rooms. This has now settled down'*. [Mrs A] clearly had significant dementia with Sundowning (wandering around which typically begins about 3 pm and continues well into the evening or early night time) at the time of her transfer to [the Home]. Moving dementia residents to other facilities can result in the resident becoming more confused in the early afternoon/evening periods with increased wandering, agitation and resistance to cares/redirection. It is clear that [Mrs A] was affected by the change in her environment initially and that her dementia increased over the period in which she was a resident at [the Home] from the progress notes: *31/7 @ 0245 [Mrs A] was wandering down hallway dressed; 13/8/06 [Mrs A] was very agitated all morning....; 15/8/06 [Mrs A] has a fixation with her washing plus becoming extremely demanding with ringing her bell so frequently; 15/8/06 Went to give her meds just after 9 pm & she was changed all dressed up ready for the day, Called out at 10pm wanting to get up so she could wash & dress; 11/7 [Mrs A] rang a numerous amount of times through the night; 30/8/06 Wandering around looking for her daughter & grandchildren & a friend. Could not understand that she lives here; 17/6/09 (actually 17/9/06) she had hidden everything in all different draws wrapped up in under things; 27/10/06 @ 11.30 [Mrs A] consistently rang her bell for 1½ hours every 2 mins; 27/10 11–7 [Mrs A] rang all night and when she wasn't ringing she was calling out help; 6/11/06 [Mrs A] playing with faeces in the hand basin had it all over places,' 12/11/06 [Mrs A] very confused this shift. She is gradually getting worse; [Mrs A] very confused wanting to wash herself all the time; 6/12/06 [Mrs A] getting more demanding stands in her doorway yelling help. Does not remember she has had shower etc; [Mrs A] taking up a lot of our time always yelling out help me; 29/12/06 11-7.00 Disruptive in the night. Calling out 'help help' waking other residents because she wants a wash in the middle of the night; [Early 2007] Continues to shout help all of the time when she is in her room. Very demanding, [Friday] Call out all day, [Friday] 11-7 Most of the time calling & yelling for help in the night. Needs attended. Wants to go to the toilet but when you put her on the commode, nothing happen'.*

[The Home] clearly tried to assess and manage [Mrs A's] dementia and demanding behaviour and ensure that she was supervised as closely as they could manage, given their staffing ratio would have been appropriate for an ordinary rest home, not dementia rest home: *'16/8/06 [Mrs A] moved to room 39 to be closer to the nurses station so that staff can keep a closer eye on her; 18/08/06 still needs a high degree of supervision, 6/11/06 [Mrs A] playing with faeces in the hand basin had it all over places. Given a shower'*. A challenging Behaviour Monitoring Form was commenced on 20/12/06 and continued until [Saturday] inclusive: *'3pm 20/12 Yelling out (?word) amy wanted nothing; 7.45pm 20/12 Yelling out help me; 18.15 (no date) Yelling out help me help me she think I am her daughter; 20.00 hrs (no date) Yelling I want you! I want you! Help! Help! Yelling for nothing; [Early 2007] 9pm–11pm was yelling out Nurse, help from the time she was put to bed until 11.30pm wanting a wash even though she had had a shower; 9pm [Two days later] Very uncooperative kept her up a bit later in the TV Room so she would sleep. Residence said she was yelling out help all the time. Very demanding'*. [Mrs A's] behaviour was difficult to manage in an ordinary rest home and would have been more appropriately managed within a dementia rest home. I question why she was deemed to be rest home level of care, at the time of her admission to [the Home], rather than dementia rest home where the staffing ratio would have been higher and the staff specifically trained to look after dementia residents.

[Mrs A] was admitted to [the Home] with a documented history of falls and a previously fractured hip, which presumably occurred from a fall, as described on the Support Needs Assessment dated 1/6/06: *'#NOF L) 8/2/06... Falls'*. Assessment and care planning occurred to minimise the risk of falls as above under assessments. Despite the preventions put in place, i.e. the cot-sides for nocte falls and being moved to Room 39 for closer supervision, [Mrs A] continued to fall and had 17 falls documented on the Unwanted Event Reporting Form during her time at [the Home]. She had 5 falls from 23/7/06 to 9/8/06 inclusive, prior to the decision to manage the falls with cot-sides: *'23/7/06 5.34 am bedroom; 3/8/06 7.30 bedroom; 7/8/06 7.15 pm bedroom; 9.8 (night time & bedroom); 9/8/06 0800 room'*. The rest of the falls occurred following the decision to use cot-sides when in bed, but actually occurred when the cot-sides were presumably not in place and were predominantly during the evening and morning periods: *'11/8/06 (? Time bedroom); 31/8 2135 bedroom; 29/9 1030 R39; (?Date but in early August) 0300 bedroom; 6/11/06 11.00 bedroom; 9/11/06 11.00 BR; 13/11/06 19.00 bedroom; 17/11/06 1030 bathroom; 17/12/06 0845 Rm 39; 23/12/06 7.15 am Rm 39; 23/12/06 8.40 pm bedroom; [Friday] 1630 Rm 39'*. Eleven of the falls documented on the Unwanted Event Reporting Form were not documented within the progress notes; *'3/8/06; 7/8/06; 9/8/06; 11/8/06; 31/8/06; ? date (early August); 9/11/06; 13/11/06; 17/12/06; 23/12/06'*

There were two falls documented in the progress notes which has not been documented on the Unwanted Event Reporting Form: *'(24/7) cont she said that she was frightened and she did not know how she fell down; 15/8/06 @ 0300 [Mrs A] fell'*. The Policy For

Unwanted Events states: *'6. The unwanted event report is completed on an Unwanted Event Form by the staff member who: 6.1 is involved in the unwanted event. 6.2 witnesses the unwanted event, or 6.3 to whom the unwanted event was reported'*. On two occasions, as documented above, a fall was not documented on the Unwanted Event Reporting Form. The Policy For Unwanted Events states: *'11. If the unwanted event affects a resident, their contact person is notified'*. The Communication with Families/Friends/Agents Form has the following family fall notifications: *'24/7/6 [Mrs B] - Spoke about [Mrs A's] fall & facial injuries sustained on morning of 23/7,' 8/8/06 Message left on phone for [Mrs B] notifying her of the fall (17 Fall on 7/8/06); 6/11/06 [Mrs B] - Reported the fall and flap laceration of yesterday... ; 23/12/06 [Mrs B] - Reported fall to family'*. Only four of the total of 19 falls were notified to the family.

[Mrs A] was seen by a physiotherapist on 14/11/06 to assess her head position as stated: *'[Mrs A] very frail. Chin on chest. Sleeps in sitting position and head falls forward.... Trial collar — however it does not help head position a lot as head flexed forward from thoracic level... She also has very poor bed mobility. Plan To wear collar by day. To sleep with maximum 2 pillows — <u>not</u> tri-pillow Agree with NASC referral'*. The Short Term Problem Management Sheet dated 22.11.06 states: *'Nursing Problem: 22.11.6 Hyperflexon of Head, Expected Outcome with Timeframe: Continued, Nursing Intervention: No Tri-pillow. 2 pillows only at night. Put on bed for sleep after morning tea & after lunch, 2/24 turns'*. This is a long term problem documented on a short term care plan. There is a section at the end of the Lifestyle Plan for a problem which was not typed in but this section had been used for another need. There is no other section in the Lifestyle Plan for the Registered Nurse to document a long term problem newly identified. I note the Resident Mobility Assessment for Safe Handling which was completed on 13.7.06 was not updated. On her initial assessment, [Mrs A] was identified as being independent and clearly [Mrs A's] mobility had changed as the physiotherapist stated she had poor bed mobility as above. [Mrs A] was not reassessed by the Registered Nurses and her Lifestyle Plan updated accordingly.

A referral from [Dr I] dated 21 November 2006 was sent to Health Services for Older People which states: *'[Mrs A] has been at [the Home] only since June. She has deteriorated a lot in that time with falls, and recently her head has fallen forward to the point that she is looking at the ground all the time. No significant injury noted although neck xray arranged. Rest home management feel she is almost hospital level care now'*. [The] DHB Home & Older Adults Service responded to the referral acknowledging it and informing the Doctor that [Mrs A] should be seen within 20 days. The Home & Older Adults Service reassessed [Mrs A] on 11/12/06 when she was deemed to be at hospital level.

The reassessment by [the] DHB Home & Older Adults Service dated 11/12/6 states: *'Change of Needs Identified since last Assessment: Incontinence with Bowel &*

Bladder. Needs feeding because of her cervical Kyphosis — with difficulty. Has been mobilising with a frame'. The DHB Aged Care Residential Agreement states:

'D16.3 Care Planning
You must ensure that:

d. Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status;

g. The Care Plan addresses the Subsidised Resident's current abilities, level of independence, identified needs/deficits and takes into account as far as practicable their personal preferences and individual habits, routines, and idiosyncrasies;
j. Each care plan focuses on each Subsidised Resident and states actual or potential problems/deficits and sets goals for rectifying these and detail required interventions;
k Short term needs together with planned interventions are documented by either amending the Care Plan or as a Short Term Care Plan attached to the Care Plan,'
1. Care plans are available to all staff and that they use these care plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

D16. 4 Evaluation

a. You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier'.

[The Home] is contractually obligated to comply with the DHB Aged Care Residential Agreement for Subsidised Residents, there is no evidence that [the Home] reassessed [Mrs A's] bowel, bladder and feeding needs and altered her Lifestyle Plan accordingly. As mentioned above, [the Home] did change [Mrs A] onto a [puréed] diet but did not assess her formally or by a Dietician and alter her Lifestyle Plan accordingly.

My Opinion

Prior to [Mrs A's] admission to [the Home] she was reassessed as rest home level of care, following a previous assessment as hospital level care. At the time of her admission to [the Home], it was evident that [Mrs A] was a very high rest home level and may have been more appropriately cared for in a dementia rest home. In my opinion, [the Home] generally gave an adequate standard of care to [Mrs A] and which was more than could be reasonably expected of a rest home level as evidenced above.

However, I believe that [the Home] should have requested a reassessment of [Mrs A's] care level earlier given her deterioration with her dementia and related behaviours which

were clearly impacting on other residents and demanding more than normal amount of input and supervision from staff. The Doctor's referral to Home & Older Adults Service related that rest home management felt [Mrs A] was almost hospital level care now, there is no comment about the dementia related behaviours which clearly had been impacting on other residents and the staff as I stated above. [Mrs A] clearly required a lot more care including feeding and incontinence cares which were not reassessed and the Lifestyle Plan altered accordingly, however it is evident that [Mrs A] generally received adequate care. [The Home] should have informed the GP of the weight loss and either requested the GP to refer [Mrs A] to a Dietician for a review or initiated it themselves. In my opinion, I believe the delay in requesting reassessments and the lack of assessment and evaluation of the Lifestyle Plan would be viewed with slight disapproval.

2. Was [Mrs A] provided with appropriate analgesia throughout her stay at [the Home]?

[Mrs A] was admitted to [the Home] with a history of pain. [The DHB] Assessment dated 1/6/6 states: *'Pain: gets pain in L) leg at times esp at night. Hx Rotar cuff injury — Both hips / R) arm carpal tunnel syndrome 1/ L) arm'.*

The Registered Nurse Assessment 09/06/06 states: *'Pain needs managing (ticked) at night'.* The Registered Nurse Assessment does not identify where [Mrs A] experiences pain but does identify that it occurs at night; there is no separate pain assessment completed. The Lifestyle Plan does not have a section for pain management and there is no notation on the Lifestyle Plan regarding [Mrs A's] pain management.

The progress notes have the following entries which mention pain: *'29/7 3–11 She was complaint at 2100 her legs sore. I gave her night medication, and it's a great relief; 8.11.06 9–11 [Mrs A] says she fell and picked herself up when going to the DR for lunch, Says she has a painful L hip. Given Paracetamol; 1200 [Mrs A] walked freely and without pain to her room — about 309 metres having claimed to have fallen; 15.12.6 gave [Mrs A] 2 panadol at 1500 complaining of a headache; 17.12.6 Found on floor... complaining of pain head, may need supplementary analgesia; 19.12.06 @ 0300 [Mrs A] complained of cramp in her R hip gave her 1/1 Panadol; 28/12 11–7 [Mrs A] complained of sore on her Lt leg. Panadol given @ 02:20 Hr and placed comfortably on bed; 28/12 1545 hrs S/B [Dr I] re pain in L) groin ? # pelvis — taken to [xray] by daughter — results to be rung through to Dr; [Saturday] 3-11 When we change her we saw her left thigh is swollen... Report to the [RN] (Manager) (C Manager). She will come tomorrow morning and check leg. I give her 20 mls Elix Paracetamol; [Saturday] 11-7 [Mrs A] Lt leg from (femur to knee) was swollen, painful, tender + warm. [Ms E] informed Keep her on bed to immobilise the Lt leg; [Sunday] 8-4 [Mrs A] stayed in bed L) leg swollen above knee, seems to be in pain. Not in this condition am yesterday & was walking with frame. Ambulance called, family notified. Fell Friday night see accident form'.*

[Mrs A] was seen by a physiotherapist on 14/11/06 to assess her head position as stated in the progress notes: *'NB She denied any neck or thoracic pain throughout my visit or intervention. She did say that she had pain in the inside of the top of her head — possibly cervical thru her neck extensors being at such stretch'*. As above in Question One, a Short-Term Problem Management Sheet was completed for the Physiotherapist's management plan, however, this did not identify the pain that [Mrs A] had admitted to with the Physiotherapist nor any plan to manage the pain.

[The] DHB Home & Older Adults Service Assessment Summary dated 11/12/6 states: *'Other Issues: Pt has given soft collar: now been referred to orthotics. Neck is painful: needs reg pain relief'. Pain/Aches Present, but not in last 24 hrs; Consistency of Pain: Intermittent; Comments: Nagging pain most of the time L) side head and down L) side neck Relieved by Paracetamol. [Mrs A] says it doesn't wake her at night'.*

The Medication Chart had the following analgesia charted: *'Regular medication 8/6/06 Paracetamol 500 2 bedtime — Discontinued date 1 4/11/06,' 1 4/11/06 Paracetamol 500 2 B/Fast, 2 Lunch, 2 Bedtime; Non Regular Medication: 8/6/06 Paracetamol 500 2 qid prn'*.

One Medication Administration Record (Signing Sheet) has four entries for Panadol that was given to [Mrs A] on a PRN basis. These entries are for the following dates: *'19/12 1/1 0300; 26/2 20 ml 5.20; 28/12 20 ml 02.20; 6/1 20 mls 22.45'*.

The [Home's] Policy for Pain Management states: *'Residents with cognitive or sensory impairment are assessed and monitored by observing pain indicators, such as facial grimaces, vocal complaints, body language, reduced mobility, aggression and resistiveness to care. Pain scales, such as the UAB Pain Behaviour or Abbey, are used for these residents... A multi disciplinary approach to managing the pain is taken, which will include a comprehensive physical examination... Methods other than medications are considered when managing pain... While an on-going pain management plan is being developed, the provisionary treatment plan is reviewed at least weekly, or more often if the resident's condition deteriorates. The effectiveness of the treatment is evaluated after each dosage or treatment is given. This may be recorded in the resident's progress notes, although if the pain is persistent, an evaluation and monitoring from, eg Short Term Problem Management Form, should be used. When the pain is being effectively managed, the pain management goals/targets and strategies are documented in the resident's Lifestyle Plan, evaluated and reviewed as necessary'*. It is clear from the Lifestyle Plan that this did not occur, however as stated above, there was no section available for the Registered Nurses to document pain management. I note that the [Home's] Policy for Pain Management was reviewed on July 2007. This policy was originally created in November 1996. My assumption, therefore, has to be that the policy was no different during [Mrs A's] tenure with [the Home].

My Opinion

[The Home] administered the regular analgesia as prescribed. PRN analgesia was given irregularly following the change from regular Panadol daily at night to Panadol regularly three times daily. There is no evidence that [Mrs A] was given PRN analgesia prior to the change in the regular Panadol regime on 14/11/06. Clearly the Doctor must have felt that [Mrs A] required more regular analgesia to have changed the charting and increased the amount of regular Panadol, but this is not reflected in the PRN analgesia administered. There is no evidence of any pain assessment being conducted at any time during [Mrs A's] tenure with [the Home] nor any pain management care plan developed. In my opinion, [the Home] did not adequately assess or plan appropriate pain management or provide adequate analgesia to [Mrs A]; this would be viewed with moderate disapproval.

3. Did [Mrs A] receive timely and appropriate appointments with her GP during her stay at [the Home]?

The DHB Aged Care Residential Agreement states:

D16. 5 Support & Care Intervention

e. Primary Medical Treatment

i. You must ensure that:

1. *each Subsidised Resident is examined by a General Practitioner within 2 Working Days of admission, except where the Subsidised Resident has been examined by a Medical Practitioner not more than 2 Working Days prior to admission, and you have a summary of the Medical Practitioner examination notes. After the initial examination, the Subsidised Resident must be examined not less than once a month and as clerically indicated (as assessed by a Registered Nurse), except where the Subsidised Resident's medical condition is stable as assessed by the General Practitioner, in which case the Subsidised Resident may be examined by a General Practitioner less frequently than monthly, but at least every three months. This exception must be noted and signed in the Subsidised Resident's medical records by the General Practitioner'.*

[Mrs A] was admitted to [the Home] on 7 June 2006 and medically admitted on 13/6/06, 4 working days following her admission. [Mrs A's] file did not contain any evidence of a medical review within 2 working days prior to her admission, so the medical admission was not compliant with the DHB Aged Care Residential Agreement's timeframe. [Mrs A] was seen by her GP on 27/6/06, 4/7/06/ 25/7/06/ 1/8/06, 10/8/06, 15/8/06, 17/10/06, 14/11/06, 20/11/06, 28/11/06, 12/12/06, 28/12/06. [Mrs A] was admitted to [the public] Hospital on [Sunday in early 2007]. These dates demonstrate that [Mrs A] had regular medical reviews which occurred more often than the monthly medical review required by the DHB Aged Care Residential Agreement, except for one period of two months review i.e.

15/8/06 then reviewed next on 17/10/06. On the 17/10/06 medical entry it states: *'3 m review... see 3m'*. Clearly the GP intended [Mrs A] to be reviewed at 3 monthly intervals from the 15/8/06 review but had not documented this exception to the DHB Aged Care Residential Agreement.

I cannot comment on the medical reviews in relation to [Mrs A's] health status on 27/6/06 and 4/1/06 and her progress notes as [the Home] was unable to locate her progress notes from her admission up to 24/7/06. However the 4/7/06 medical review was related to her bilateral leg wounds and at which time the GP placed her on antibiotics as stated: *'4.7.06 recheck wounds bilat legs — generally improving, still inflamed — G/u Fluclox'*. The medical review on 25/7/06 followed a fall on 24/7/06. The GP's reviews appear to be in response to requests by [the Home] as the GP reviewed either her wounds or conducted a physical review following a fall or falls as stated: *'1/8/06 MRSA pos wounds not healing; 10.8.06 Falls x 5 15.8.06 Slid off commode this morning; 17.10.06 3m review. Recent diarrhoea — campylobacter; 14.11.06 Fall 2 w; 2 0/1 1/06 discussed with dtr [Mrs B] — head down + now sideways — pain L) side of head to left head — xray — ? due or cause of recent falls x 4... — rapid deterioration; 28/11/06 ACC form done re fall 6/11; 12/12/06 Not tolerating new collar; 28.12.06 Says fell 1 w ago 23/12 in care note, pain L) groin since'*.

The progress notes have the following references to any phone contact with the GP or medical reviews that were conducted by the GP: *'1/8/06 [Dr I] has prescribed Co-trimoxazole to start tonight for leg ulcers; 15.8.06 S/B [Doctor] for physical check; 1/9/06 Swab taken, Dr advised re wound status ABS tonight; 17/10 S/B Dr HH for 3/12 R/V Bloods ordered — Digoxin level; 8.11.06 Risperidone withheld at midday due to excessive sleepiness and medication review requested of [Dr I]; 14/11/06 S/B [Dr I] for position of head (on chest) and falls. NASC referral to be made, Physio to see for ? collar; 21/11/06 S/B [Dr I] — noted deterioration. For chest x-ray. Neck x-ray; 27/11/06 S/B [Dr I] to refer to Orthotic Clinic for a more suitable neck collar. Physio suggested xray; 28/12 1545 hrs S/B [Dr I] re pain in L) groin. ? / Pelvis — taken to [xray] by daughter — results to be rung through to Dr'*.

On 6/1/06, [Mrs A] developed a swollen left thigh which deteriorated during the night as it clearly became more swollen and was reported to be painful, tender and warm as stated in the progress notes: *'[Saturday] 3–11 [Mrs A] not in her bed. When we change her we saw her left thigh is swollen. Report to the RN (Manager) (C Manager). She will coming tomorrow morning and check her ... I give her 20 mls Elix Paracetamol; 11-7 [Mrs A] Lt leg from (femur to knee) was swollen, painful, tender & warm. [Ms E] informed. Keep her on bed to immobilise the Lt leg'*. There is no evidence that [Mrs A's] clinical observations were taken to assist in assessing whether she needed urgent medical attention, particularly as [Mrs A] had recently been medically reviewed on 28/12/06 for a painful left groin at which time [Mrs A's] GP organised an x ray.

[Mrs A] was clearly reviewed by a Registered Nurse on [Sunday] and was sent to [the public] Hospital at 1220 as stated in the progress notes: *'8-4 [Mrs A] stayed in bed L) leg swollen above knee, seems to be in pain. Not in this condition am yesterday & was walking with frame. Ambulance called, family notified. Fell Friday night see accident form … TO [the public hospital] 1220'*. There appears to be a significant delay in [Mrs A] being sent to [the public] Hospital, as I presume the Registered Nurse would have commenced work at either 8 am or 8.30 am and I would have expected her to review [Mrs A] immediately she started duty following the two requests from the on duty staff during the afternoon and night duties.

My Opinion

The medical and progress note entries indicate that [Mrs A] was reviewed by her GP at times when she required more frequent medical review for her health status, particularly around her wound and falls, including possible causes. In my opinion, [Mrs A] received timely and appropriate medical reviews during her tenure at [the Home] up until 6/11/06. In my opinion, the on duty staff during the afternoon and night duty shifts on [Saturday] appropriately contacted the on call Registered Nurses for advice; they should be commended for realising the significance of [Mrs A's] leg status and for following up by seeking Registered Nurse advice in a timely manner.

In my opinion, the on call Registered Nurse (Manager ? C Manager) for the 3–11 timeframe on [Saturday] did not adequately respond to the phone call from the on duty staff regarding [Mrs A's] swollen leg, did not request the duty staff to take clinical observations to assist in her decision for [Mrs A's] care and whether medical advice should be sought. This resulted in an unnecessary and vital delay to [Mrs A] receiving appropriate and timely medical intervention.

In my opinion, the on call person, [Ms E], who was available during the 11–7 time frame on [Saturday to Sunday], did not adequately respond to the request by the on duty staff regarding the leg swelling and the new information stated in the progress notes that the leg was painful, tender and warm; she did not request the duty staff to take clinical observations in order to assist her decision as to whether [Mrs A] required urgent medical attention. Her decision not to seek medical advice was inappropriate and caused an unnecessary and vital delay to [Mrs A] receiving medical intervention.

The admission to [the public] Hospital did not occur until 1220. I understand that [the Home] would have to wait for an ambulance to arrive but in my opinion, the Registered Nurse who organised the ambulance should have done so immediately following her assessment of [Mrs A] which should have occurred on her arrival at work. In addition, the Registered Nurse should have made the situation clear to St Johns Ambulance and the clear necessity for urgent medical review and admission to [the public] Hospital. In my opinion, this lack of appropriate follow up to the on duty staff by both the RN (? C Manager) and

[Ms E] who were on call and the Registered Nurse who organised the hospital admission on [Sunday] would be viewed with severe disapproval.

4. Was [Mrs A] provided with appropriate bowel care?

The Registered Nurse Assessment dated 09/06/06 states: *'Elimination Bowel Continence 1. Continent (ticked); Bowel Routine 1. How often/when: Daily'*. The Assessment of Pressure Area Risk Using The Norton Scale dated 04/06/06 states: 'Continence Total Control No incontinence 4 (scored)'. The Incontinence Assessment (not dated) states: *'No problems. Fastidious with cleanliness, Commode in room nocte'*. The Resident Dietary Information form states: *'Resident Special Dietary Requirements & Instructions for Cook: NIL'*. The Lifestyle Plan dated 13/07/06 states: *'Elimination Continent (ticked). Monitor & support independence. Ensure regular daily bowel action by discrete enquiry. PRN aperient ordered; [Thursday] Fleet enemas PRN'*. There is no nutritional plan in the Lifestyle Plan to ensure that [Mrs A] received adequate fibre in her diet to assist her bowels and help prevent constipation.

[The Home] is unable to locate any of [Mrs A's] bowel charts, apart from one bowel chart which has one entry dated 31/12/06. The progress notes states: *'25/7/06 3.41 Her daughter said she's diarrhoea but there's no problem with her this shift 25.9.060645 [Mrs A] has now put faeces in her bed = diarrhoea has now commenced; 25.9.06 Continued diarrhoea this morning — approximately 6 episodes; 26.9.06 No diarrhoea in the night; 26.9.6 Faecal specimen collected; 27.9.6 A more normal bowel motion today; 6.11.06 [Mrs A] playing with faeces in the hand basin had it all over places. Given a shower; 30.12.06; 1120 — Microlax enema given as xray showed no pelvic fracture but faecal loading 1330 — No result from Microlax. Fleet enema given with fairly large result. Put back to bed wearing a pad 3. 11pm 3 x more BMs; [Thursday] Given fleet enema with a very good result'*.

The diarrhoea episode which was documented on in the progress notes on 25/9/06 occurred following both [Mrs A] and her daughter contracting food poisoning from food purchased when out for lunch as stated in the progress notes: *'25.9.063.11 Daughter rang tonight to tell us that [Mrs A] had been out to lunch with sister [at the weekend]. They had both had a chicken sandwich. Sister became ill late Sunday night, probable food poisoning'*. The progress notes demonstrate that [Mrs A] received adequate care for this event, including a faecal specimen being taken for diagnostic purposes.

[Mrs A] was xrayed to check whether her pelvis was fractured with the xray result showing faecal loading. [Mrs A] was treated with Microlax and Fleet enemas with good results from the Fleet enemas.

The Medication Chart states: *'Regular Medication 8/6/06 Lactulose 10 ml ... Non Regular Medication: 15.8.06 Metamucil 20g PRN; [Thursday] Fleet enema 1 PR pm'*. A Non Packaged PRN Medication Administration Record states: 1000 ml Lactulose Syrup

10g/15ml take TEN ml each morning. Take with a large glass of water. The Lactulose was first documented as being administered on 20/6 with the last entry 7-1. This regular medication was not given on a daily basis as prescribed. The Metamucil has not been recorded if or when it was given on a Non Packaged/PRN Medication Administration Record. Normally Metamucil would be given on the breakfast meal and if given a second time, on the 5 pm meal. A Microlax enema was given on one documented occasion (in the progress notes), this has not been charted on the Medication Chart nor on a Non Packaged/PRN Medication Administration Record; however I was not supplied with [the Home's] medication policy, so I am unable to confirm whether they have standing orders for medication including Microlax enemas. The Fleet enema was given on two documented occasions (in the progress notes) but again they haven't been recorded on a Non Packaged/PRN Medication Administration Record.

My Opinion

[Mrs A] was admitted fully continent with her bowels but clearly on regular medication for bowel management. As noted above in Question One, [Mrs A] became incontinent of her bowels, this change in her needs was not reassessed nor an appropriate care plan developed. Her regular Metamucil was not recorded as given and the Lactulose was given irregularly despite being prescribed regularly. There were no reasons stated within the progress notes as to why the Metamucil and Lactulose were not given/regularly given. There was no evidence that [Mrs A's] bowel regularity was assisted with appropriate nutrition and Fortisip with fibre added. With [Mrs A's] dementia and associated short term memory loss, it would have been extremely hard for the staff to monitor [Mrs A's] bowels as she self toileted and she would not necessarily have been able to remember whether she moved her bowels or not. However, as her need for more assistance became apparent, then the staff should have been able to monitor her bowel movements more accurately and manage any constipation accordingly. In my opinion, [the Home] did not give adequate bowel care and this would be viewed with moderate disapproval.

5. Was [Mrs A] provided with appropriate wound care?

[Mrs A's] reassessment by [the] DHB's Home & Older Adults Service dated 1/6/6 describes frail skin with skin tears as stated: *'Skin Has skin tears — frail skin — needs to be covered at all times'*. The Registered Nurse Assessment dated 09/06/06 states: *'Skin Integrity. 6. Skin Tears easily. 9. Other Very delicate skin'*, The Lifestyle Plan states: *'Skin Integrity. Pressure Area Risk L (circled). Emolients to skin BD. —Aqueous cream. Dressing to leg wound — see folder & follow instructions. Must wear compression stockings daily. Ungvita to heel L) *SEE DRESSINGS FOLDER ATTEND AS INSTRUCTED WOUND MRSA +ve - OBSERVE CONTACT INFECTION CONTROL'*. There is no reassessment of [Mrs A's] pressure risk or associated care plan in the Lifestyle Plan to manage and prevent any further skin breakdown from occurring as a result of the sacral areas on her upper left and right buttocks mentioned on the Wound Care Plan and Management Sheet dated 25/8/06 (see below).

The earliest Wound Assessment & Monitoring Form is dated 20.7.6 and refers to a map. This form is partially completed with three sections not commented in: % of total wound floor, Pain (Severity) pt's estimate (0-5) and Other Foreign Bodies: haematoma. Other (State which). This form does not have all the data filled out eg Date of birth, Nurse supervising wound care, location of wound, origin of wound, date of initial assessment, wound type. I assume this form to be about the left leg from the information on the map. This form has four documented assessments and only the first two assessments are initialled with no designation. There are several Wound Care Plan and Management Sheets, none of which have the data completely filled out. Some of the wound Care Plan and Management Sheets have two wound areas documented eg *'I) leg 7.8; L) Leg 15.8; 1) Forehead 2) nose'*. With two wound areas documented on the same Wound Care Plan and Management Sheet, it makes it difficult to determine whether both wounds are being dressed with the same products or which wound they are referring to when documenting; one example is as stated on: *'30/9/06 Redressed with NSaline, Vita cream applied & dry (telfa) dressing, tubifast applied. Lesion broken dry & healing'*. Wound Care Plan and Management Sheets also have changes in the plan documented under the Initial Wound Care Plan eg: *'USE IODOSORB NOW NOT SLIVER. ABSOLUTELY NO TAPE NO OPSITE'*. There is no date for this change in plan. There is one documented use of Iodosorb on this Sheet '*1.8.6 N/S Iodosorb Telfa tub compression stockings'*, then the products used describe *'25/8/06 dry dressings applied — clean Broken areas upper buttock L & R — dry dressing applied; 2 6/8/06 Wounds cleaned with N/S, & interpose dressing applied'*. I note that this particular Sheet now documents two more wounds on the left and right upper buttocks.

The Wound Care Plan and Management Sheet for the left knee describes the use of Bactroban, which is an antibacterial cream that must be prescribed, as stated: *'8.12 Saline wash Bactroban, 10.12 saline wash with Bactroban; 11.12.06 Saline wash, Bactroban, 12.12.06 Saline wash Bactroban; 13.12.06 Saline wash Bactroban*'. The Medication Chart supplied by [the Home] has regular and non regular medication documented on it. [The Home] has not supplied a Medication Chart with topical medication. None of the Non Packaged /PRN Medication Administration Records supplied document the applications of Bactroban. There is no entry in the progress notes about the application of Bactroban.

The Medical Progress Notes describe [Mrs A] being reviewed on 12/12/06 but do not mention the left knee wound or the use of Bactroban.

The progress notes state: *'She was bleeding in her face. She had skin tear on her nose and bruised on her forehead and small skin tears as well; 24.7 Dressing done by [the RN]; 1/8/06 [Dr I] has prescribed Co-trimoxazole to start tonight for leg ulcers; 16.8.06 Wounds to L) leg moistened. Healing well; 18.8.06 The left leg wounds are much reduced in size & healing quickly with silver dressings. Other small skin tears x 2 are due to sticking plaster — please use 'remove' for any such dressing but preferably don't use it at all; 19/8/06 her dressing been done, Both legs and her*

pressure sore around coccyx area; 25/08 Has 2 raw areas on her bottom — 1) Comfeel applied on both sides of bottom. 2) cushion to sit on, 3) Egg shell mattress put on bed; 31/08/06 Wounds looking not so good. Action: 1) Elevate legs, 2) daily dressing, 3 Pressure stockings; Bottom looking worse — Action: 10 soft cushion at all times, 2) recline backward in chair — less pressure, 3) zinc ointment; 1/9/06 swab taken. Dr advised re wound status ABS tonight; 25.9.6 Tegaderm applied to sacral area to protect new skin. Heels padded with Allevyn pads. Nurse side to side with heels off the bed,' 26.9.06 [Mrs A] has skin breakage on lower spine needs a dressing; 18.10.06 Heels continue to require appropriate measure to prevent pressure sores from forming. Allevyn heel pads & sheepskin boots — Vitamin A ointment. Sacrum also needs continual monitoring; 7.11.06 @ 0130 [Mrs A] requested we take her pressure boots off — on being told we cannot do so until morning before she gets up, she became disturbed & requested we phone her daughter to come here to take them off. Changed her position; 5.11.06 Fell on her left side & caused a flap laceration to her left dorsum of her hand (?word) Apasition was good & fixed with steristrips. Opsite was used over adaptic; 16.11.06 [Mrs A] knocked her leg when caregiver putting on her stockings causing a skin tear to R) leg, 31.11.06 [Mrs A's] skin tear on dorsum of hand has healed well 22.12 Dressing done to R) leg L) knee healed; 23.12.06 Skin tear caused when falling cleaned & dressed, 26.12 Dressings done'.

The progress notes indicate that the wounds were evaluated and plans developed to manage the wounds and prevent further deterioration in the wounds at times. Wound products used included silver and Idosorb which are specifically used in wounds requiring antimicrobial dressings. [Mrs A] was placed on an egg shell mattress (25/8/06) and a soft cushion to assist in prevention of pressure areas. I am unfamiliar with an egg shell mattress and whether it was appropriate to give the required amount of pressure relief [Mrs A] required. However, clearly the egg shell mattress was not sufficient to meet [Mrs A's] needs as her heels required Allevyn heel pads and sheepskin boots on 18/10/06 for protection as well; neither of which are sufficient to prevent skin breakdown on the heels with a low body weight, poor bed mobility (as documented by the Physiotherapist) and her assessed high pressure area risk. A swab was taken of a wound (? which one) on 1/9/06 and the Doctor advised who then prescribed antibiotics.

The [DHB] Examining Clinicians notes states: *'Presenting Problem(s) symptoms/Duration: Referred by ED, painful swollen L) thigh; History of Presenting Problems(s): Staff noted painful swollen L) high ? duration...Alert and answering short questions... left leg — L) thigh swollen ++ tender + + ? warmer a small couple of purple patch behind knee; Problem List (Active and Inactive) Left swollen thigh... Sepsis ? cause ... Plan Thigh Xray ... patient unwell + + ... Tachycardic + + purple 2 patch behind knee spreading to? Possibility of thigh infection (necrotising fasciitis)'.*

[The] DHB Clinical notes state: *'ED Reg [Sunday] 1420h 'rs OE Unwell. T 37.4 P 73 BP 76/42. Swollen L) thigh & leg, pain + + on movement; 7/1/7 Gen Surg Reg 1900h*

PC ? necrotising fasciitis L) leg... WCC 20.0 Patient clearly septic. Med Reg noted blotchy discolouration L) leg lateral aspect at knee. Appears to have progressed whilst in resus. ? Necrotising fasciitis No other cause for sepsis identified. Clinically there is progressive blotchy discolouration of leg which is consistent with necrotising fasciitis; [Sunday] [Doctor] Generally unwell for last several weeks ... presented with swollen L) leg started 2/52 ago ... progressive blotching discolouration L) leg, Temp 37.4 ... L) leg Bruise no ulcer flactuant (? Word) heel cold L) foot no cyanosis swollen & grossly tender Blanching & discolouration of L) Leg; [Sunday] Nursing Pt arrived on ward at approx 2130. Necrotising fasciitis on L) leg skin intact, L) lower area appears cold to touch, the upper limb is purple blotchy blanch areas… Pt has arrived on ward with pressure area to both heels skin broken 2 grade'.

My Opinion

[Mrs A] was given adequate wound care generally while at [the Home]. Appropriate wound products for management of infected wounds were used; tape was not used to secure dressings when it was identified that [Mrs A's] skin tore on removal of the tape, wounds were dressed at regular intervals and swabs were taken of the wounds with antibiotics prescribed by the GP. It was clear by the changing wound products that [the Home] staff did reassess the wounds, however, it was not always clear which wounds were being referred to or that the wound management plan was followed accurately. Wound management plans were in place, although they were not always completed and were difficult to follow with more than one wound documented on a Wound Care Plan and Management Sheet. There was only one Wound Assessment & Monitoring Form documented on, all subsequent wounds were only documented on Wound Care Plan and Management Sheets. The two forms could be reviewed and simplified so that it is easier and more user friendly for the Registered Nurses to document assessments, reassessments and wound care plans for each wound separately and for the staff to follow.

Some measures were put in place to prevent and manage pressure areas i.e. an egg shell mattress and a cushion. It is clear that the egg shell mattress and the cushion provided assistance in pressure relief but were not sufficient to prevent further pressure areas as [Mrs A] required continual monitoring of her sacrum and heels and her heels had broken down to a 2 grade level prior to her admission to [the public] Hospital on [Sunday] as above. [Mrs A's] heels were further protected by Allevyn heel pads and sheepskin boots, these should not be necessary on an appropriate relief mattress. I believe that [Mrs A] should have been placed on a pressure relief mattress such as an alternating air mattress. If that level of mattress was not enough to prevent further pressure areas then [Mrs A] should have been assessed by an Occupational Therapist or Physiotherapist who was trained to assess mattress and cushion needs. [The Home] is contractually required to provide appropriate equipment as per the DHB Aged Care Residential Agreement which states:

'D15, 3 Facilities and Equipment

a. You must provide communal aids and equipment for personal care or the general mobility needs of Subsidised Residents who require them, including (but not limited to) pressure relief (including mattress, heel protectors and seat cushions)'.

In managing wound care, it is important that excellent nutrition and weight management is also part of the wound management plan. As discussed in Question One, [the Home] did not inform the GP of the ongoing weight loss or have a Dietician review [Mrs A].

In my opinion, [the Home] did give adequate wound care to [Mrs A], however they could and should have ensured that her nutritional needs were met and the most appropriate mattress and cushion were available and used to prevent further pressure areas. The documentation of the wounds could have been written up more clearly and the wound assessments should have been documented more clearly. In my opinion, the standard of documentation, lack of nutritional review and good management and the standard of the pressure relief mattress and cushion would be viewed with slight disapproval.

6. Were [Mrs A's] clinical observations monitored appropriately?

[The Home] took [Mrs A's] baseline observations of temperature, pulse, respirations, blood pressure and weight on admission, which they recorded on the Medical Profile on Admission. The Policy for Resident Admission & Orientation dated *'Date Reviewed: October 2006'*, requires a new resident to have the following observations recorded as stated: *'On admission, new residents have the following assessments: 12.5 Temperature, pulse, respiration, weight and urinalysis (within 24 hours)'*. Although this policy was not applicable for [Mrs A's] admission date of 7 June 2006, it appears that this was a requirement at the time of her admission as the Medical Profile On Admission form states: *'Date Issued: October 2005; Recordings on Admission: Weight, Temp, Pulse, Resps, BP, Urinalysis'*. There is no evidence that [Mrs A's] urinalysis was done on admission or within 24 hours.

[Mrs A's] admission blood pressure was also recorded on the Blood Pressure Chart where the subsequent blood pressure measurements were recorded. [Mrs A's] blood pressure was recorded next in July, one month later. The blood pressure was not recorded in August or September but was recorded twice in October, three times in November and once in December. I note that [Mrs A's] blood pressure dropped from an admission recording of 124/64 to 98/60 on 6/10/06 and that the blood pressure was taken again on 22/10/06 which demonstrated a further drop to 90/60. There is no evidence that [the Home] informed the GP of the low blood pressures they were recording. There is no evidence that [Mrs A's] lying and standing blood pressure was checked either at the time of the falls or over a few days to see if there was a drop on the standing blood pressure and whether that could be a factor in her falls. The GP recorded [Mrs A's] blood pressure as 130/70 on 25.7.06, 114/60 on 10.8.06 and 125/? (number not visible on medical notes photocopy) on 15.8.06;

I note that the GP took [Mrs A's] blood pressure on 17/10/06 and recorded a higher figure of 150/70.

[Mrs A's] temperature and pulse were checked on 23.7.06 following a fall; this was recorded on the Unwanted Event Reporting Form dated 23/7/06 and in the progress notes. Her temperature was recorded on 25/9/06 at 10 pm when [Mrs A] was unwell with diarrhoea and vomiting. [Mrs A's] observations were recorded on 22.11.06 following her xray and because she was very sleepy. The progress notes state: *'T36.2, P80 and strong, regular, BP 78/44 and her pupils very small but responds to light. Her colour is poor — pale. She had been taken to an independent physio-therapist. Doctor asked to visit and assess her condition if she does not rally with fluids after a sleep'*. [Mrs A's] blood pressure was very low and was not checked again by [the Home]. The Doctor did not visit that night; [Mrs A] was responding and drinking fluids well, according to the progress notes. There is no evidence that [Mrs A's] temperature and pulse were taken at any time when her wounds were swabbed for signs of infection. There was no evidence that any recordings of temperature, pulse, respirations and blood pressure were taken when [Mrs A's] leg became swollen, painful, tender and warm in [early in] 2007.

Please refer to Question One for comments on [the Home's] clinical observation of [Mrs A's] weight.

My Opinion

[The Home] took regular recordings of [Mrs A's] weight and blood pressure, but did not appear to follow up on the noticeable drops in recordings. [The Home] did not initiate any lying and standing blood pressures to assist in determining causes of [Mrs A's] falls. I am aware that it might be considered a doctor's responsibility to request lying and standing blood pressures and that the GP did not request this, however, the Registered Nurses did have a responsibility to initiate assessments, including lying and standing blood pressures, in order to assess [Mrs A] and to inform the GP of their findings. [Mrs A] had a consistently low blood pressure and if she dropped it on standing, this would be a causative factor in her falls. [The Home] did not take [Mrs A's] temperature and pulse when they clearly suspected wound infections. They did not take her temperature and pulse to assess her when [Mrs A] was clearly unwell with her swollen leg on [Saturday and Sunday], particularly as she had been reviewed by the GP on 28/12/06 for a painful left groin. In my opinion, this lack of assessment by taking clinical observation recordings, particularly for [early] 2007, would be viewed with moderate disapproval.

7. [Mrs A] did not receive blood and urine tests, as requested by her daughter, when she saw [Dr I] on 28 December 2006. Was this appropriate? Did [Ms D] have any responsibility to follow-up this request with [Dr I]?

It is reasonable for [Mrs A's] daughter to request blood and urine tests for her mother. [The Home] is able to take a urine specimen at any time they feel is clinically warranted providing

there is no local requirement by the laboratory for the GP to order the MSU (urine test). The GP generally writes out a blood test form as they clinically make the decision which blood tests are appropriate to order, however GPs do request Registered Nurses to fill out blood test forms for them at times when it is a phone consultation.

In this situation, it is not clear whether [Dr I] was asked by the Registered Nurse about the daughter's request for blood tests. There is no evidence in either the progress notes or the GP medical notes regarding such a request. The medical notes state: *'28.12.O6 MSU done'*. It appears from this entry that [Dr I] was under the impression that an MSU had been taken by [the Home]; this clearly did not occur as there is no evidence of a report for an MSU in the medical file for this date, the last MSU report being dated 15 Nov 2006.

[Ms D] responded to Rae Lamb, Deputy Commissioner in a letter dated 13/11/07 which states: *'[Mrs B's] main issue seems to be with blood and urine tests that she had requested of me to be done. With this request in mind I ensured that she was seen in clinic by her doctor, who also was needed to examine her for discomfort in her left groin area. I was not present at the examination and was unaware that the question of the test had not arisen. My custom is to leave a note attached to the front of the chart with any queries for the doctor. (As an RN I do not have the authority to order blood tests). The doctor did not note any clinical indication for either blood or urine tests during his examination. Nonetheless, I assumed that these had been attended and when asked by [Mr B] about the results, assumed again that results were negative, since I had received no instructions about treatment from the doctor, who receives results directly and follows up immediately where necessary'*.

My Opinion

In my opinion, [Dr I] should have been informed of the daughter's request for blood tests and her reasons why she felt that [Mrs A] required these tests. [Dr I] would have made his clinical decision as to whether any blood tests were warranted and would have ordered them if he felt they were required. The Registered Nurse should have documented in the progress notes that the GP was informed of the daughter's request and his response to that request. The daughter should have been informed by the Registered Nurse of the GP's decision whether blood tests were or were not warranted or ordered and this communication documented in the progress notes or on the Communication with Families/Friends/Agents form. The daughter should also have been informed by the Registered Nurse of the results of any blood or urine tests that the GP decided to order.

It is clear that the Registered Nurse must have informed [Dr I] that an MSU had been taken as he has written this in his medical file in a way which implies he was informed an MSU had been taken. I can only assume that there was miscommunication about the MSU between [Ms D] and the Registered Nurse who attended [Dr I] when he examined [Mrs A].

[Ms D] stated in her letter that her custom was to leave a note attached to the front of the chart for the doctor. In my opinion, this practice would leave room for the note to fall off and therefore the doctor, and the attending Registered Nurse, would not be aware of any queries. I believe that a safer practice would be to write out a list of queries regarding residents on a separate file note for the doctor and attending Registered Nurse to refer to.

[Ms D's] assumption that the blood and urine tests had been attended to and the results negative, in my opinion, implies negligence on [Ms D's] part in not following up on the family's request for results. [The Home] clearly received copies of any laboratory results as the laboratory results actually state *'Copies: [The] Home'* and it would have been a simple matter for [Ms D] to have checked [Mrs A's] file for the results and then informed [Mr B] of the results. [Ms D] would then have immediately realised that the blood and urine tests had not been taken and could have followed up with [Dr I]. If [Ms D] had read [Dr I's] entry in his medical file on 28/12/06, she would have noted that he assumed the MSU had been taken.

In my opinion, [Dr I] would have considered ordering blood tests and made an appropriate clinical decision if he had been informed about the daughter's request; however, it is unknown as to whether he was or was not informed about the daughter's request. Clearly when [Dr I] conducted his physical review of [Mrs A] in relation to her left groin, he did not order any blood tests. In relation to the urine test it is clear that [Dr I] had assumed the MSU had been taken. In order to determine whether blood tests were appropriate at the time of this medical review, this question should be asked from a medical point of view.

In my opinion, [Ms D] was responsible to follow up with the daughter's request for blood and urine tests and to ensure that [Dr I] was consulted about the request and that any blood or urine tests ordered actually occurred. In addition, [Ms D] was responsible to ensure that the daughter was communicated with and informed of the Doctor's decision regarding her request and any results from tests ordered. As Care Manager, [Ms D] is responsible for the care of the residents and must ensure that they receive all care required and this would include follow up of family requests for blood and urine tests. In my opinion, [Ms D's] lack of follow up to ensure that the daughter's request for blood and urine tests and her response to the family's request for the results of the tests which included assuming they had been done and were negative and her communication with the family would be viewed with moderate disapproval.

8. Are there any aspects of the care provided by [Ms D] or [the Home] that you consider warrant additional comment?

No."

Appendix B

Relevant Rights and policies

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

…

(5) Every Consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

(4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where —

(a) it is in the best interest of the consumer; and
(b) reasonable steps have been taken to ascertain the views of the consumer; and
(c) either, —
(i) if the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would have made if he or she were competent; or

(ii) if the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider."

[The rest home] Policy for Resident Admission and Orientation[12]

…

9. A resident profile, preliminary assessment and short term care plan are documented on the same shift as the resident was admitted or at most within 24 hours of admission. The last is replaced after three weeks following admission when a long-term lifestyle plan is completed. A review of this plan is conducted every six months or more often if the resident's circumstances or condition changes.

[The rest home] Policy for Unwanted Events[13]

…

5. The unwanted event report is completed or an Unwanted Event Form by the staff member who:
5.1. is involved in the unwanted event
5.2. witnesses the unwanted event, or
5.3. to whom the unwanted event was reported

…

10. If the unwanted event affects a resident, their contact person is notified.
11. Details of the unwanted event are recorded in the resident or staff member's notes.

[The rest home] Policy for Pain Management[14]

…

2. A resident with pain who is able to participate in the process is assessed by a registered nurse, using a tool, such as the McGill Questionnaire.[15] The onset of the pain, its location, duration, type, aggravating and relieving factors and treatments already tried are included in the assessment.

…

[12] Issued November 1999; reviewed October 2003. Although this document states that it should have been reviewed in October 2005, Ms H advised that it was the Policy in effect at the time of Mrs A's Admission.

[13] Issued December 1999; reviewed November 2004. This Policy was also reviewed in July 2006, where the relevant steps became numbered 6, 11 and 12. No other changes were made to the relevant steps.

[14] Issued November 1996; reviewed June 2005 and July 2007.

[15] *McGill's Present Pain Index* is used to measure pain using a 0–5 scale; 0 = no pain and 5 = excruciating pain.

8. While an on-going pain management plan is being developed, the provisionary treatment plan is reviewed at least weekly, or more often if the resident's condition deteriorates.

9. The effectiveness of the treatment is evaluated after every dosage or treatment is given. This may be recorded in the resident's progress notes, although if the pain is persistent, an evaluation and monitoring form … should be used.

10. When the pain is being effectively managed, the pain management goals/targets and strategies are documented in the resident's Lifestyle Plan, evaluated and reviewed as necessary.