A Rest Home

General Practitioner, Dr D

A Report by the

Health and Disability Commissioner

(Case 02HDC15234)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mr B	Complainant (son of consumer)
Mrs B	Complainant (wife of Mr B)
Ms C	Daughter of consumer
Dr D	General Practitioner/Provider
Ms E	Principal Nurse Manager at the rest home
Dr F	Vascular Surgeon
Ms G	Registered Nurse
Ms H	Registered Nurse
Dr I	General Practitioner
Dr J	Locum General Practitioner
A Retirement Village Group	Provider
A Rest Home Company	Provider/Licensee
A Retirement Village	Provider

Complaint

The Commissioner received a complaint from Mr B and Mrs B about the services that were provided to Mr A at a retirement village from January until May. They raised a number of concerns about "the lack of care given to Mr A during the four months he was a patient at the secure unit" at the retirement village. The complaint was summarised as follows:

The Rest Home
The rest home did not provide Mr A with services of an appropriate standard between January and May while Mr A was a patient in the retirement village secure unit. In particular:

- *Staff did not respond appropriately to Mr A's deteriorating condition, including his:*
  – toe and foot symptoms and associated pain
  – ear irritation or discomfort
  – incontinence and the resulting skin irritation and scalding
  – oral thrush
  – skin condition on his face, head, ears, hands and arms.

- *Staff did not adequately inform Mr B, who held an enduring power of attorney in relation to Mr A's personal care and welfare, about Mr A's deteriorating condition and options for treatment.*

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Dr D
Dr D, general practitioner, did not provide Mr A with services of an appropriate standard between January and May while Mr A was a patient in the retirement village secure unit. In particular Dr D:

- *Did not respond appropriately to Mr A's deteriorating condition, including his:*
  - *toe and foot symptoms and associated pain*
  - *skin condition on his face, head, ears, hands and arms*

- *Did not adequately inform Mr B, who held an enduring power of attorney in relation to Mr A's personal care and welfare, about Mr A's deteriorating condition and options for treatment.*

An investigation was commenced.

Information reviewed

- Information provided by the retirement village group
- Information provided by Dr D
- Information provided by the Hospice
- Information provided by the Health Centre
- Information provided by the Private Hospital
- Information provided by Mr and Mrs B
- Information provided by the District Health Board
- Responses to my provisional opinion from the retirement village group
- Responses to the provisional opinion from Mr and Mrs B.
- Independent expert advice was obtained from Dr Keith Carey-Smith, general practitioner with experience in caring for the elderly, and Ms Wendy Rowe, registered nurse.

Information gathered during investigation

Overview
This case involves the care provided to Mr A in the secure unit at a retirement village over a four-month period from mid-January to mid-May. Mr A was an 88-year-old man who suffered from dementia, diabetes and peripheral vascular disease. His son and daughter-in-law (Mr and Mrs B) raised a number of issues concerning his overall care, which are addressed below. Their key concern related to his significant deterioration during the time he was in the secure unit and the fact that he developed gangrene of his right foot over this

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period despite being in 24-hour care. Mr and Mrs B consider that the retirement village failed to provide Mr A with appropriate care, and that this contributed to his overall deterioration and subsequent death. On 20 May Mr A was transferred from the retirement village to the public hospital in town for management of gangrene of his right foot. From there he was transferred to a hospice for palliative care, and then to a private hospital in another town, to be closer to his family. He died in June.

Background
A chronology of events is attached as Appendix 1.

The retirement village is controlled and administered by a rest home company, which is a fully owned subsidiary of a retirement village group. The rest home company is the licensee of the retirement village. The contact for the licensee was the Director of Nursing at the retirement village group. As licensee, the rest home company was responsible for the standard of nursing services provided by the retirement village.

On 18 January Mr A, aged 88, was transferred from a studio flat to the specialised dementia care unit (the unit) at the retirement village where he had lived for several years. The retirement village is a fully integrated retirement village offering a range of services including apartments, studios, rest home care, secure dementia level care and general and psycho geriatric hospital services. The unit was intended to improve the ability of people with dementia to cope and function within the physical environment of a secure specialised dementia unit.

The retirement village group explained that Mr A was transferred to the unit because, although he managed well in his studio flat in the previous year, his confusion began to increase and on numerous occasions he wandered and required assistance to return to his studio. He also had periods of aggression, which were attributed to his brittle insulin-dependent diabetes, as once his blood sugar levels were under control his aggression subsided.

The unit "nursing assessment on admission" form, completed by staff when Mr A was admitted to the unit, set out his initial nursing assessment. This form stated that Mr A's presenting medical diagnoses were diabetes and short-term memory loss. The form also recorded that because of Mr A's diabetes his diet should be observed. It was later recorded that he might require a banana or similar food throughout the night to maintain his blood sugar at satisfactory levels. It was also noted that Mr A had normal eyesight, hearing and speech, that he had upper and lower dentures, a missing thumb, his facial skin could become dry, and he could become unsteady and fall on uneven ground. In addition to the above conditions, Mr A had longstanding peripheral vascular disease (PVD). The registered nurse who completed the admission form advised that this information was obtained from the studio notes, Mr A and his family. The "front page of clinical notes" form recorded that Mr B had power of attorney over "property and health", and Mrs B power of attorney for property.

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Toe and foot symptoms and associated pain

Mr and Mrs B were aware of, and concerned about, Mr A's toe and foot problems, which deteriorated over a period of months prior to his admission to the public hospital in May. They said that both they and Mr A constantly mentioned these concerns to staff at the retirement village from as early as August the previous year, and noted that by late that year Mr A had red streaks up his toes. They felt that little was done to manage his pain and that staff "did not recognise that he needed pain relief". Mr and Mrs B advised that Dr F (vascular surgeon) told them that Mr A's aggression and wandering, which had led to his admission to the unit, had been compounded by the pain in his foot caused by his deteriorating circulatory condition and complicated by his diabetes. Mr and Mrs B allege that, despite this matter being brought regularly to their attention, staff at the retirement village took no action until Mr A's toe turned black, and only then began to dress it properly. Mr and Mrs B were also concerned about Dr D's response to Mr A's toe and foot problems, and commented that "it appears that [he] didn't have the experience, awareness and perception to recognise the early stages of gangrenous breakdown of [Mr A's] toes". Mr and Mrs B stated that at the end of May, the attending house doctor, Dr D, and the manager of the unit, Ms E, tried to persuade them to agree to the amputation of Mr A's foot. Mr and Mrs B considered that this course of action was inappropriate because only half of Mr A's foot and three toes were black and he had poor overall health.

The retirement village group response

The retirement village group advised that Mr A's peripheral vascular disease (PVD) coupled with his diabetes caused the difficulties with management of the breakdown and eventual gangrene of his right foot. They considered that the deterioration was properly treated by Dr D and staff in the unit, in consultation with Dr F. They highlighted specific notes in the clinical records increasing in frequency from March, which recorded Mr A's foot problems and the action taken by staff to address these.

The retirement village group's wound management policies required that the treatment plan for dressings be well documented in the nursing care plan and logged in the dressing book or "similar/wound management chart" by a registered nurse. The retirement village group acknowledged (in response to comments made by my expert nursing advisor) that the nursing care plan did not detail the day-to-day treatment of Mr A's foot dressings. However, they commented that the nursing care plan referred the nurse/carer to the wound management chart, which directed and plotted the care given to Mr A. This was considered best practice in the unit, because wound care can change frequently, and the practice avoided reproducing information. Additionally, as dressings were undertaken twice daily it was appropriate that a wound management chart was available to ensure staff signed off that the dressings had been completed.[1]

[1] This view is supported by Registered Nurse Ms H (a registered nurse employed by the retirement village), who also responded to my first provisional opinion. She commented:

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The retirement village group provided me with a report it commissioned from registered general nurse Ms G,[2] which noted that the wound care charts provided considerable information, including on the condition of the wounds, cleansing solutions used, types of dressings, progress and/or deterioration and size of wounds, pain experienced while dressing being attended to, instructions for treatments, and reference to the nursing care plan. In their response to the provisional opinion, the retirement village group provided further advice from Ms G, who emphasised that "in spite of some difficulties finding the relevant information, I did find clear evidence that professional, compassionate care was provided to Mr A, adequately meeting his need in all areas, by a wide, multi-disciplinary team". However, she also noted that "the wound care chart needs to be reviewed to allow for clearer assessment and planning of treatment". She commented further that her comments on the documentation were intended as "a recommendation and as a way to move forward in an environment of continual change towards best practice …".

In response to Mr and Mrs B's concerns about the proposal for amputation, the retirement village group advised me (following their own inquiry into this complaint) that the nurse manager and Dr D believed that by May, amputation of Mr A's foot was a viable option to treat the inexorable deterioration of his foot, exacerbated by his diabetes and PVD, and that although they knew that it would not prolong his life, they believed it would give him a better quality of life and decrease his pain. The retirement village group also noted that in Dr F's response to the referral dated 18 April, he viewed amputation as a viable option and discussed it with the Mr and Mrs B.[3]

In response to the complaint that staff at the retirement village failed to recognise or adequately respond to the pain in Mr A's right foot, the retirement village group stated that staff at the retirement village were vigilant regarding his pain levels and needs.[4] The

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> "I have had an opportunity to view the nursing progress notes. I can comment that the wound chart was to be a working document derived for the benefit of staff directly involved so that everyone was aware of the circumstances and the wounds that needed dressing and changing. In any event it is my opinion that the staff (including the Principal Nurse Manager and the registered nurses) would have communicated verbally with each other as to what was required.
>
> In regard to the comment regarding apparent confusion over which foot was being treated, I can recall that we did create a separate wound management chart for both the left and right foot. However, these were subsequently combined on the one chart, which is not uncommon. This was to ensure that records remained together and were easily understandable and accessible to the GP and the nursing staff. I accordingly dispute what the NEA [Nurse Expert Advisor] says."

[2] Ms G has 17 years' experience in gerontology and is currently part-owner, director and nurse administrator of a retirement village.

[3] See letter to Dr D dated 18 April, relevant details of which are set out in this report at page 8.

[4] This view is supported by Registered Nurse Ms H, in response to my first provisional opinion. She commented:

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retirement village group's pain management protocol required that a resident's pain be assessed and monitored by using the resident orientated pain assessment scale and questionnaire, and that a pain control programme be entered into the nursing care plan by a registered nurse. If a resident was unable to express his or her level of pain, the policy required evaluation through the observations of registered nursing staff. These findings were required to be recorded on a pain chart. The retirement village group explained that a pain management or pain score chart was not used to assess the pain in Mr A's right foot because the progress notes were considered to be the most effective way of communicating the multiple and complex needs of residents in the unit. Furthermore, a pain management chart – which relies on a resident's ability to score their own levels of pain – could not be completed owing to Mr A's diagnosis of dementia. The retirement village group stated that, in its view, staff adequately reviewed Mr A's pain levels and communicated these issues effectively to Dr D, who responded appropriately. Staff also recorded Mr A's pain levels during wound dressing changes, on the wound dressing charts.

The retirement village group also advised me that their staff responded appropriately to Mr A's pain by administering pain relief as prescribed by Dr D, updating assessments and requesting further intervention from Dr D to ensure more effective pain relief was prescribed, as Mr A's pain relief needs changed over time. The retirement village group also advised, in response to my expert nursing advice concerning the administration of morphine, that two nurses signed the controlled drugs register when morphine sulphate (MST) was administered to Mr A (a copy of the drug register was provided). In these circumstances, only one staff member was required to sign the medication signing sheet.

"In my opinion, the foot pain was well managed by the RN and the multidisciplinary team. Pain management in elderly patients, particularly with dementia, is complex and difficult:

- Assessment of the degree of pain often has to be done indirectly, such as by reaction to dressing changes, rather than directly from the patient. In [Mr A's] case, there were direct complaints of foot pain noted during March and April, with pain associated with dressings noted throughout.

- All analgesics have side effects, in direct relation to the potency of the pain relief. Using a step-up approach, commencing with paracetamol, then stronger agents such as paradex, and moving on to weak opiates (DHC) then strong (morphine), all prescribed regularly, is recommended. Side effects of the more potent agents, in particular drowsiness, causes increased risk of immobility falls, reduced fluid intake, and chest infection. In this case, it is not known if the terminal deterioration was in any way hastened by the analgesics. If so, this risk has to be weighted against the suffering and distress of pain.

I further comment that it is difficult to assess the extent of pain that a dementia patient is experiencing as you are unable to rely on the accuracy of what the patient is telling you due to their fluctuating levels of confusion. I can say that all documentation was passed onto the GP at regular intervals and that the GP visited the patient every Monday or as required throughout the week."

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Dr D

In response to the complaint about his involvement in Mr A's toe and foot problems and associated pain, Dr D advised that he had worked for five years at the hospice in conjunction with his general practice, and specialised in palliative medicine and pain management. He began working at the retirement village in 1998, and took over Mr A's care when Mr A's previous general practitioner, Dr I, left general practice. Dr D recalled that Mr A did not, as Mr and Mrs B allege, complain of a sore toe for 18 months. The GP who assessed him in August the previous year did not record this problem, nor did another doctor who assessed Mr A in December.

Dr D advised that specific issues with Mr A's right foot were first brought to his attention on 21 March. He saw Mr A on 25 March, and noted poor circulation and a wound on the third toe, which was swabbed and the specimen sent to the laboratory. Pain relief was increased. Further review was undertaken by Dr J while Dr D was on leave. Changes to the dressings of the toe were recommended and commenced. On 8 April, as the area on the middle toe appeared to be worsening, a referral to Dr F was initiated, which noted an "ischaemic/gangrenous middle toe ®".

Dr D submitted that he appropriately assessed and treated Mr A's right foot and toes and requested appropriate laboratory tests, prescribed antibiotics and referred Mr A to Dr F for assessment as his condition deteriorated. Dr D stated that he increased Mr A's pain relief appropriately but found it increasingly difficult to care for him adequately in the unit as his fluid intake fell and his confusion increased. Dr D explained that Mr A's overall physical condition probably deteriorated in May because of the toxins from the gangrene in his right foot and the effects of his pain relief.

Dr D recalled that when he advised Mr B that his father was to be admitted to the public hospital on 20 May, he did not present amputation as the only treatment option. He suggested that "a below knee amputation was an option for palliative care rather than life prolonging". The family were aware of other options following their meeting with Dr F on 24 April.

Dr D noted a letter from Mr B, which was faxed to the retirement village on 26 March. The letter stated that "there is to be no resuscitation or treatment of any type or degree to be taken". He interpreted this as applying to an acute collapse and giving good palliative care to Mr A (including the importance of making him comfortable), but not necessarily prolonging his life. Dr D recognised that the appointment of Mr B as Mr A's attorney enabled guidance on decisions regarding medical intervention.

Records

The studio notes record that Mr A complained of sore feet on 7 July the previous year. This appears to have been relieved by a change in his footwear. Further records indicate that Mr A also complained of sore feet on 27 August and an area on the toe of his right foot was assessed by a podiatrist on 12 October. Dr D recorded that Mr A had "dry feet/corns" at his consultation on 27 October.

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There is no record in the medical notes that staff were concerned about the condition of Mr A's feet and toes on admission to the unit. The first recorded instance of concern about Mr A's feet and toes in the unit was on 2 March when he complained that his right foot was very painful.

Further notes record concern about the right foot and the actions taken by staff in response, on 11 March, 14 March, 18 March, 21 March, 23 March and 25 March. On 25 March Dr D first saw Mr A specifically to examine his feet. He prescribed antibiotics and a GTN patch[5] for Mr A's foot during the day and regular pain medication. In addition, bandaging and a soft sheepskin were ordered with a bed cradle to be placed on the bed at night to prevent pressure on the foot.

On 26 March the GP visit and findings were recorded as being discussed with Mrs B by Ms E, Principal Nurse Manager, "advising of circulation problems to feet r/t long term history of diabetes, the area on toe, Rx of antibiotics and GTN patches, dressings and wearing of boot and inappropriate toileting in room and wetting foot. Advised [Mrs B] we may need to purchase wide soft footwear at some point if [Mr A] discards the boot."

Further nursing notes throughout March and April record ongoing concerns with Mr A's foot wound, including the type of dressing used and his pain response to dressings.

On 4 April Dr J, locum for Dr D, was asked by nursing staff to reassess Mr A's toe. At that time Dr J removed the nail, noted the absence of ankle, foot and popliteal pulses, and diagnosed peripheral vascular insufficiency causing delay in wound healing. He recorded a change in wound dressing and set careful parameters for the monitoring of Mr A's blood glucose.

On 8 April, Dr D reassessed Mr A's feet and referred him back to Dr F (vascular surgeon) for review and management of his "ischaemic/gangrenous middle toe ®".

On 18 April Dr F reviewed Mr A and recorded "gangrenous change in the middle toe of the right foot which extends back to the interphalangeal joint". Dr F concluded:

> "Clinically, this man has severe occlusive disease which is almost certainly of the typical diabetic distribution, being mainly tibia perineal. This has resulted in critical ischaemia of the right foot. He currently appears to be suffering from quite severe pain. Simple amputation of the toe would of course inevitably fail and is not a solution to the problem. Although arteriography with a view to revascularisation is theoretically an option, I think, given his age, the underlying diabetes, and the other co-morbidities, any attempt at revascularisation would be misguided. This then leaves us with one option which is below knee amputation.

[5] A medicated dressing designed to promote circulation.

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> I outlined these options to the nurse who has accompanied him this evening and she will be in touch with [Mr A's] son.
>
> Obviously he will have to give consent to whatever decision is made about future management. I will therefore wait for him to get in touch with me and we will proceed from there."

On 24 April Dr F saw Mr and Mrs B in his rooms to discuss the options for management of Mr A's toe. Dr F records in his letter to Dr D, "Both [Mr and Mrs B] have decided they wish to take a conservative approach to the management, which of course will simply entail managing his pain."

On 25 April the nursing care plan recorded the decision for conservative management of Mr A's right foot and requested vigilance in pain management. Dressings continued twice daily.

Throughout early May there are extensive notes outlining pain management and ongoing deterioration of Mr A's right foot. The nursing records articulate a concern to balance the side effects of pain relief (drowsiness, confusion and unsteadiness on his feet) with effective alleviation of Mr A's ongoing pain. There are documented contacts with Dr D regarding pain management on 6, 7, 8, 13, 19 and 20 May and subsequent alterations to Mr A's pain medication.

On 20 May, following further assessment by Dr D, Mr A was referred to the public hospital for advice on the management of advancing gangrene and PVD in his right foot, and appropriate pain management.

Incontinence and scalding

Mr and Mrs B allege that throughout the period Mr A was in the unit there was a persistent smell of stale urine in his room and throughout the unit. They state that "the stench of urine" was not removed by the methods explained by the retirement village during the times they visited. They said that when Mr A was living in his studio he apparently did not use his toilet to urinate. Nevertheless his studio and bedding did not smell of urine.

Mr and Mrs B also commented that they noticed Mr A in wet (caused by urination) but drying trousers many times when they visited him. On other occasions they noticed that he had wet trousers that had dried out, and other visitors had also reported to them incidents where Mr A had been found in wet clothes. They recalled being told at the private hospital[6] that Mr A had developed severe long-term scalding and was in great discomfort when he urinated. Mr and Mrs B wondered whether he suffered scalding because staff in the unit did not assist him to change his clothing. They reported that, unlike the retirement village, staff at the public hospital fitted Mr A successfully with a catheter to allow healing and to relieve the pain when he urinated.

[6] On 30 May Mr A was transferred from the hospice to the private hospital in a town, to be nearer Mr and Mrs B.

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The retirement village group advised that initially staff in the unit followed the care plan dated 16 September 2001, which had been completed while Mr A was living in his studio. This care plan stated that Mr A was incontinent owing to loss of muscle tone and the ageing process, and required constant supervision and assistance to maintain continence. This plan was updated on 1 March and identified that Mr A required prompting every two hours to use the toilet, and an evaluation of the plan on 28 March recorded "incontinence in room an issue".

The retirement village group explained that people with dementia, such as Mr A, often lose the ability to discern where it is appropriate to urinate. Mr A would pass urine in places not designed for toilet use. During its internal inquiry, the retirement village group found that the staff who regularly cared for Mr A in the unit considered that he was continent with a two-hourly toileting regime, and was relatively easy to direct to the toilet. However, in the last six weeks of his time at the unit Mr A experienced greater difficulty in urinating in his toilet because his walking was affected by the pain in his left foot. Sometimes his urine "dribbled" on his footwear and clothing. On other occasions he spilt fluid on his clothing as his grip was affected owing to the previous amputation of one of his thumbs.

Staff assessed Mr A's continence in the unit and concluded that he was continent on admission but required assistance with appropriate toileting.[7] Staff attempted to address Mr A's inappropriate urination by using continence nappies, disposable nappies at night, a uridome, and a specially placed bucket in his bedroom, but these efforts were not successful. A catheter was not used because staff were concerned that in view of his dementia and mobility he would remove it (as he had done with the uridome) and damage his urethra. A special continence pad was placed on Mr A's bed at night to prevent his mattress from becoming wet, and his bed linen was kept clean and odour free with the use of these continence appliances.

The retirement village group noted that while Mr A's inappropriate urination was not uncommon it was very challenging behaviour. Mr A was not always co-operative with removing his clothing when wet, and there were numerous recorded occasions when staff changed Mr A's clothing and dressings. The retirement village group also stated that there was no evidence in the medical notes of the retirement village, the public hospital, the hospice and the private hospital that Mr A experienced long-term scalding.

The retirement village group's policy on the management of urinary and faecal continence required that a registered nurse undertake a comprehensive continence assessment, establish an individual continence programme and document this in the nursing care plan. The retirement village group's policy on uridomes required that the type of uridome used be documented in the nursing care plan.

[7] This view is supported by Registered Nurse Ms H, who stated in response to my first provisional opinion that she was of the view that Mr A had inappropriate toileting rather than an incontinence problem.

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The retirement village group also stated that for the majority of Mr A's stay, and on other occasions as required, his carpet was cleaned by staff at least twice a week with a wet and dry vacuum cleaner. Pot-pourri oils were also used, and a private company sanitised and deodorised his carpet on 11 February.

Dr D said that he investigated the cause of Mr A's episodes of incontinence with appropriate tests, but there was no evidence suggesting an infection. Dr D stated that no excoriation from urine was seen on Mr A's body while he was at the retirement village, and it was not recorded as being seen on admission to the public hospital.

Oral thrush

Mr and Mrs B recalled that in December 2001, prior to his transfer to the unit, Mr A developed oral thrush (a yeast infection). He had obvious symptoms of a swollen dirty tongue, offensive breath, white spots and dry lips, and was unable to chew his food and swallow. Mr and Mrs B advised that they informed the staff, but the condition was not successfully treated in the unit. In response to the provisional opinion they commented that the fact that "no notes were made about thrush does not necessarily mean that he didn't have it".

The retirement village group advised that while he was in the unit, Mr A required assistance to complete his oral cares in the morning and at night, but that there is no indication in the records that he developed thrush during this period. The retirement village group acknowledged that Mr A required treatment (Nilstat) for a mouth condition at the hospice, and assistance with mouth care at the private hospital every two hours, but stated that this was most likely associated with his treatment with antibiotics at the hospice, and his continued deterioration.

Dr D also stated that Mr A did not have oral thrush at the retirement village. Dr D thought it possible that Mr A developed oral thrush after he was prescribed antibiotics in the public hospital, as thrush is a known side effect of antibiotic therapy.

Skin condition

Mr and Mrs B recalled that prior to his transfer to the unit, Mr A developed a skin condition on his face, head, ears, hands and arms, which caused him to shed skin. The condition deteriorated while in the unit, and they allege that it was not properly treated by nursing staff. As a consequence of their concern Mr and Mrs B took Mr A to the emergency doctors and were subsequently referred to a pharmacy for treatment. They purchased toiletries for Mr A's skin and requested the retirement village staff to ensure their use. Despite this, when Mr A was admitted to the public hospital he had visible red scaly patches on his head, ears and face.

The retirement village group stated that nursing staff at the retirement village regularly treated Mr A's skin condition with moisturising creams, and that after 3 April, when the condition of the skin on his face was last recorded (as improving), Mr A had no further skin problems in the unit. On 22 March Mr A was assessed by a dermatologist, who was "most

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satisfied" with the condition of his skin. The notes from the private hospital do not indicate that staff were concerned about the skin on Mr A's face when he was admitted.

Dr D advised that there were a number of actions taken by Mr A's previous GP in relation to his skin. These included assessment and treatment of solar keratoses on his hands and referral to a consultant dermatologist. Further requests by Mrs B for consultant intervention were followed up, and appropriate assessment and treatment initiated. On 22 March, the consultant dermatologist reported to Dr D that Mr A's skin was "in reasonably good condition" and no further follow-up was recommended at that stage. Dr D further advised that there is no evidence in the records of the doctors who assessed Mr A prior to his transfer to the unit, or on his transfer to the public hospital, that he had a serious skin condition.

Ear irritation
Mr and Mrs B stated that at the public hospital and the private hospital staff observed Mr A pulling his ear and pushing his finger into it so roughly that the skin split. Mr and Mrs B believe that a longstanding wax problem in Mr A's ears did not receive the regular attention it required while he was resident in the unit.

There is no information in the retirement village records pertaining to concerns about, or treatment of, Mr A's ears. The retirement village group did not comment specifically on this issue in their response to this complaint.

Communication
Mr and Mrs B stated that they were kept very much in the dark about Mr A's condition despite the fact that Mr B held an enduring power of attorney in respect of his father's personal care and welfare. They visited Mr A either alone or together eight times during his residence in the unit, between 18 January and 20 May. They realised that he was likely to deteriorate and accepted this. However, they were upset because they felt they were not kept informed about his condition by Dr D and staff at the retirement village, particularly when his condition began to deteriorate markedly from March. Mrs B advised that Dr D did not contact her by phone prior to 20 May or leave a message. (Mr B advised that he could not recall such contact.)

The retirement village group's policy on resident and family consultation states that the staff recognise the importance of resident and family consultation. Further, the retirement village group's policy on incident and accident reports states that the nurse manager or registered nurse is required to contact relatives to inform them of an "incident", which is defined as anything untoward that is a source of potential or actual harm. The retirement village group advised that its internal inquiry found that staff and Dr D comprehensively discussed with Mr and Mrs B the care and treatment of Mr A and concerns about the deteriorating condition of his feet (leading to gangrene). Mr and Mrs B also had a meeting with Dr F on 24 April to discuss the issue. The nurse manager believed that nursing staff had regular and appropriate contact with Mr and Mrs B, and she had a number of meetings of an "impromptu/informal nature" with Mrs B.

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In response to the provisional opinion, Mr and Mrs B's stated that "while there was contact with [the retirement village] on the dates listed, the contact was most often initiated by us".

Dr D responded that he communicated adequately with Mr and Mrs B about Mr A's condition. He repeatedly made phone calls to them and suggested meeting them at the unit. On other occasions he could get only their answering machine. Dr D said that he informed Mrs B immediately prior to Mr A's admission to the public hospital on 20 May that his foot was worsening. Dr D said that he did not indicate that Mr A's foot was completely black but said that the gangrene was spreading. Dr D informed Mrs B that an amputation below the knee was palliative but not life prolonging. He did not try to present amputation as the only option. The purpose of his referral to Dr F had been to obtain a wider range of options, which were presented to them by Dr F at a meeting on 24 April. Dr D did not accept that his management of the condition of Mr A's feet and the referral to Dr F were unduly delayed.

General information
The retirement village group's policy on nursing care plans states that the plans are "actively used to guide the delivery of care" and that only "significant changes" were to be recorded in the progress notes.

The retirement village group provided me with an aged care residential services routine quality audit undertaken by the Ministry of Health on 18 September the previous year. This audit found that "all areas are compliant".

In response to my second provisional opinion, the retirement village group noted that in the first subsequent audit report on the retirement village by Telarc (the designated audit agency for the Ministry of Health) in May the following year, all sector standard requirements had been fully met.

The retirement village group also provided me with a statement from Ms C, Mr A's second daughter. Ms C stated that she had visited her father on average two times a month when he moved to the unit, and "had no concerns whatsoever about the care he was receiving from the staff at the [retirement village]". She felt the care was excellent and commented that "neither [Mr B] nor his wife [Mrs B] have ever expressed concern to me about the care or treatment [Mr A] received while in the unit".

Response to second provisional opinion

Mr and Mrs B
Mr and Mrs B made a number of general comments about my second provisional opinion which have, where appropriate, been incorporated into the body of this report. They also noted:

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> "[We] find it frustrating that the fact there was no record in notes about some of the things we complained about means that nothing can be done about them in the investigation. It suggests that what we say didn't happen. This is of particular concern when the investigation has commented about the inadequacy of the records kept at [the retirement village], but the investigation is reliant, in Wendy Rowe's [expert nursing advisor] words, on a retrospective review of documentation.
>
> We were the only people who saw [Mr A] at all the places where he was cared for during. We saw the things we have specifically complained about, like the tear in his skin that happened on 3rd February, and was still there when he arrived at [the private hospital], like his scalding from urine (p20), like the thrush in his mouth. If service providers say that this was not the case and there are no records of these things, it leaves us feeling that the true condition of residents is not documented to avoid responsibility. We are very clear that these things did happen."

The retirement village group
The retirement village group also made a number of general comments about my second provisional opinion which have, where appropriate, been incorporated into the body of this report. They also noted:

> "Your adverse finding against [the retirement village] seems to be primarily based on the notion that alleged inadequate or insufficiently detailed documentation and record-keeping equates with inadequate nursing care. Clearly enough, it does not.
>
> …
>
> You were supplied with four supporting letters from doctors with direct experience of [the retirement village], including [Dr D], and from the podiatrist who treated [Mr A]. These were all to the effect that the standard of nursing care at [the retirement village] at the relevant time was very good. Terms variously used by them are *'excellent service in all areas of care', 'nursing care of a very high standard', 'excellent quality of care provided; the best secure unit in [a region]', 'found the care to be professional and empathetic', [Mr A's] level of care was exceedingly good', 'one of the best health care of the Elderly units I have worked in', 'the overall standard of general and foot care is of an excellent standard in all areas of the facility'."*

Independent advice to Commissioner

General practitioner advice
The following expert advice was obtained from Dr Keith Carey-Smith, general practitioner, in relation to the care and treatment Mr A received from Dr D:

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"I have been requested to provide an opinion to the Commissioner regarding case 02HDC15234, summarised above. I have read and agree to follow the Guidelines for Independent Advisors.

I am a general practitioner in Stratford, with the qualifications MB ChB DipObst DA, and FRNZCGP, and have managed the elderly and patients in rest homes for over 30 years.

I will comment on the expert advice requested above using knowledge acquired in my training, professional development, reading, and extensive experience of patients with similar conditions to that of [Mr A].

Background and Overview
Review of the records and information supplied indicates that Dr D (or his locums) attended [the retirement village] (the Village) and reviewed [Mr A] regularly both before and during the period in question. A three-monthly review is considered appropriate for a stable elderly patient, particularly where registered nurses are regularly supervising the resident. When the foot problem developed, and [Dr D] was informed ([21 March]), visits are recorded every 1-2 weeks, again considered appropriate. On each occasion records were made by [Dr D] or his locum of the examination findings and proposed management. A gradual worsening of the ischaemia [inadequate flow of blood] and associated infection was clearly documented.

Toe and foot symptoms
The documentation clearly indicates that [Dr D] responded to the initial concern about the right foot/toes within days, appropriately examined and managed the condition, and referred appropriately. Ischaemic toes are a common progressive condition, normally treated conservatively by rest-home nursing staff with general practitioner input as necessary. Ideally, diabetic foot care should be undertaken by a podiatrist trained in diabetic foot care management, or a multidisciplinary team. However in the context of a New Zealand specialised dementia unit such as at the Village, with trained experienced nursing staff and GP, and regular podiatrist visits, the level of care provided in this case is considered to be above average. Secondary infection is common, normally treated with local measures, and if thought likely to further compromise circulation, managed with systemic antibiotics and, if necessary, local debridement [cleaning an open wound by removing foreign matter]. These measures are palliative, rather than curative, and were all carried out satisfactorily in this patient.

Referral for a surgical opinion is appropriate if significant surgical debridement is considered necessary, or if the patient is an appropriate candidate for amputation or other surgical intervention. In many cases, however, referral to a surgeon is not necessary or appropriate. In this case, a referral was made about 6 weeks after initial presentation when local measures and systemic antibiotics had failed to reverse the

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process. The surgeon noted critical ischaemia of the whole foot, with the only surgical option being below-knee amputation. After discussion with the relatives, a decision for conservative management rather than amputation was made. I consider this decision appropriate given the risks associated with amputation in an elderly diabetic patient. The referral was made at an appropriate interval in relation to onset and progress of the condition. I would note also, that appropriate monitoring of feet was carried out by both [Dr D], nurses, and podiatrist, prior to the period in question.

The patient was reported by nursing staff to be suffering pain during dressing changes over the period of nursing wound charts (March-May). When first seen by [Dr D] on 25 March, appropriate pain relief was charted (paracetamol and paradex in regular effective dose). Later visits refer to the pain being controlled (22 April), then 'very sore' (6 May). On that date stronger analgesia (DHC was introduced), followed by regular morphine, which was noted to be controlling the pain (13 May). No further note of pain is made, but clearly the deteriorating general condition overshadowed pain from around this date. I can find no reference to his left foot condition, implying that ischaemia was less severe on this side.

Pain management in elderly patients, particularly with dementia, is complex and difficult:

- Assessment of the degree of pain often has to be done indirectly, such as by reaction to dressing changes, rather than directly from the patient. In [Mr A's] case, there were direct complaints of foot pain noted during March and April, with pain associated with dressings noted throughout.
- All analgesics have side effects, in direct relation to the potency of the pain relief. Using a step-up approach, commencing with paracetamol, then stronger agents such as paradex, and moving on to weak opiates (DHC) then strong (morphine), all prescribed regularly, is recommended. Side effects of the more potent agents, in particular drowsiness, causes increased risk of immobility, falls, reduced fluid intake, and chest infection. In this case, it is not known if the terminal deterioration was in any way hastened by the analgesics. If so, this risk has to be weighed against the suffering and distress of the pain.

In my opinion [Dr D] was aware of the pain from the first consultation, prescribed appropriately, was aware of the potential for side effects (e.g. prescribing laxative with the DHC), and increased the dose and potency of analgesics correctly, appropriately balancing analgesic effect against side-effect risk.

Skin condition

[Mr A] was recorded as suffering from a number of skin conditions before and during the period in question. There is mention of skin keratoses (seen by the dermatologist), dry skin, and later (? at hospital) excoriation, and possible thrush of the mouth (neither mentioned by [Dr D] or Village staff). In the later stages [Mr A] was increasingly drowsy and incontinent, which could have resulted in excoriation,

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and thrush at hospital is likely to have been related to his terminal state and/or antibiotics. Diabetes also makes thrush more likely. [Mr A] suffered a number of falls during the last weeks, which are likely to have caused skin abrasions, cuts or bruises. Initially the foot ischaemia presented as 'dry feet with corns' in July [the previous year]. It is not clear which skin condition is being referred to in the complaint, but I am assuming that the dry skin with keratoses is the main concern. Keratosis is a common skin condition in older people who have received a lot of sun exposure. Although sometimes these lesions are pre-cancerous, treatment is primarily cosmetic, and usually involves cryotherapy (as applied in this case). [Mr A] was referred to a dermatologist for a larger lesion on the forehead [the previous] August (not by [Dr D]) but this was considered benign. The dry skin problem was managed by the nursing staff.

[Dr D's] role was to monitor the skin (in association with nursing staff and family members) for signs of malignant change, infection, or diabetic complications, and prescribe treatment or refer if necessary. From my examination of the documentation, there is no evidence that this duty was not carried out satisfactorily.

Diabetes
[Mr A] suffered from long standing insulin-dependent diabetes. This condition is likely to be responsible for the progressive peripheral vascular insufficiency causing [Mr A's] foot problems. Good diabetic control can delay but not avert the inevitable ischaemia, which is usually seen at first in one or more toes, or as ischaemic pressure areas on the heel. There is usually gradual progression from ischaemic ulcers to frank gangrene, as occurred in [Mr A's] case. At this stage there is no treatment other than conservative local measures or amputation.

Both the ischaemia, and the diabetes itself, result in an increased risk, and delayed resolution, of infection, in any wound or ulcer that develops. Even with systemic antibiotics response is slow largely due to the poor blood supply and reduced immune response. [Mr A's] age and poor general health, and previous smoking, are likely also to have impacted on his foot/toe problems, but it is impossible to determine the relative contribution of these various factors. [Mr A's] diabetes had no impact on or relationship to, his skin keratoses.

General
Records and documents indicate that [Dr D] visited (and communicated with the Village staff) regularly, and increased the frequency of visits as [Mr A] deteriorated. Diabetes monitoring by nursing staff and [Dr D] appeared satisfactory. In my opinion [Dr D] responded appropriately to the deteriorating foot circulation and general condition, and neither over- nor under-treated [Mr A]. He appeared to have a close working relationship with the nursing staff at the Village, and communicated when necessary with the relatives. There were difficulties because of the 3 hour distance from the relatives. Determining the frequency of phone contact and visits is always difficult in this situation, for relatives as well as for GP and rest home staff.

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However there was no evidence that [Dr D] was deficient in this area. [Dr D] is likely to have assumed that staff at the Village were keeping relatives informed about [Mr A's] deteriorating condition.

It is stated by [Mr and Mrs B] that [Mr A] had a sore toe for 18 months. This is not recorded in the notes, but it is possible that earlier peripheral vascular insufficiency could have caused pain. Even if detected at this stage, it is unlikely that any measures could have averted the inevitable deterioration.

Referral and hospital admission were arranged appropriately. I can think of no other measures that could have delayed deterioration, or improved pain and suffering, for [Mr A].

I consider that the care provided by the nursing staff at the Village was of very high standard and quality. Team work and communication between the Village and [Dr D] was also excellent (as confirmed by the report from [the retirement village group] Director of Nursing. The care provided by [Dr D's] locum (4 April) was also appropriate. There are no other aspects of [Mr A's] care which I consider warrant further investigation.

Summary
In my opinion, [Dr D] provided care and services to [Mr A] with appropriate care and skill over his period at [the retirement village]. I can determine no aspects of the care provided which could have been improved."

Nursing advice
The following independent expert advice was received from Ms Wendy Rowe, registered nurse, in relation to the nursing care Mr A received at the retirement village:

"I have been asked to provide an opinion to the Commissioner on case number 02HDC15234/AM. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I am a registered comprehensive nurse with 18 years of nursing experience. I have spent most of my career working in the acute medical/rehabilitation areas, and the past 3 years in the private sector. I have a Bachelor of Nursing and a Master of Arts. I currently work in a large aged care facility.

Supporting Information reviewed:

Information provided by the [retirement village group]
Information provided by [Dr D]
Information provided by [the hospice]
Information provided by [the Health Centre]
Information provided by [the Private Hospital]
Notification letter and information provided by [Mr and Mrs B]
Information provided by [the District Health Board]

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Did nursing staff in the specialised care unit at [the retirement village] provide services of reasonable care and skill to [Mr A] between January and May.

Toe and foot symptoms

Did nursing staff properly assess, monitor and treat the condition of [Mr A's] foot and toes? If not, what should staff have done?

- First reference to sore toe is on the summary of nursing notes (page 11) and in the progress notes on [2 March] as 2nd and 3rd toes **right** foot are red, hot to touch and painful (page 31).

- Entries for the [6 February] & [12 March] podiatry treatment form, not legible.

- Progress notes indicate on [11 March] corn debrided on side of **right** foot and toe pierced (page 36). Then on the [14 March] a podiatrist removed toenail, care assistant not indicating which toe in progress notes (page 36).

- Placed on wound management chart [18 March] for **right** 3rd toe. (pages 37 & 84)

- [21 March] dressing to **left** foot entered in progress notes, not identifying toe (page 37).

- [Dr D] viewed sore toe **left** foot on [25 February] and charted GTN patches daily (page 37). Progress notes (page 66) I believe to be written by [Dr D] do not identify which foot. Poor circulation and Peripheral vascular disease are noted. Summary of nursing notes indicates on [25 March] [Dr D] viewed sore toes on **left** foot and reviewed **right** foot (page 12), this is not indicated in progress notes which state [25 March] that [Dr D] only viewed **left** foot (page 37).

- [3 April] skin tear to foot reported in clinical notes did not indicate which foot (page 42). Weekly Summary by EN/RN ([enrolled nurse or registered nurse] unable to verify status) states toe was being redressed, which toe is not indicated. Assessment of toe was not known to have been completed (page 42).

- [4 April] progress notes indicate person entering was called to see [Mr A's] **left** toe. Entry indicates plan to contact GP. Unable to clarify who made this entry, whether it was a registered nurse or care assistant (page 43).

- RN entry on same shift [4 April] states that the toenail was removed by the Dr. and dressing changed (page 43).

- Medical notes [4 April] clearly shows diagram of toe where nail removed on the **right** middle toe (page 66).

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- [4 April] progress notes also indicate blood blister at base of great toe **right** foot (page 66).

- Progress notes indicate on [5 April] PNM (principal nurse manager) redressed toe and contacted family. Which foot or toe is not indicated. This entry is made by an EN (page 43).

- Progress notes indicate [8 April] [Dr D] referred [Mr A] to [Dr F]. Which toes seen by [Dr D] are not known (page 44), nor are they identified in [Dr D's] progress notes (page 65).

- Progress notes indicate that the Nurse Manager did contact son on [5 April]. This entry is not written by the nurse manager (unable to see dates on photocopied page clearly, pages 45 &12).

- Weekly summary in progress notes for [5 April]–[13 April] indicates [Mr A] is quite mobile despite his sore 'toe' (page 45). Wound management chart indicating **right** 3rd toe being attended to. Wound sizes no longer recorded (page 82).

- Progress notes for [14 April] indicate 3rd toe black and necrotic (which foot not indicated).

- Weekly summary in progress notes for [14 April]–[23 April] again say coping with his sore 'toe' (page 45).

- [24 April] progress notes indicate 'swollen and red from foot to ankle', however no input from registered staff at this stage. Also dressing between fourth and fifth toes (Left or right toes not indicated) mentioned in progress notes (page 50). Wound management chart no longer indicates size or grade of any wounds being managed.

- [25 April] PNM/RN checked foot, however entry written by unspecified person. Weekly summary in progress notes for [29 April]–[4 May] still suggests [Mr A] has a sore foot, and is coping despite a sore toe (page 53).

- Progress notes [5 May] mention 2nd and 3rd toes on **left** foot being dark mottled area (page 53). Wound management summary (page 77) has **left** foot small toe and side of foot added to wound location. Unclear as to which foot or toes being dressed with which product.

- Progress notes for the [6 May] by CNL (Care Needs Level) states that [Mr A] has gangrene wound on **right** foot. Also DHC (morphine) prescribed for pain. Also on this date it states he has 2 small skin tears on **left** foot (page 54).

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- Diagram dated the [8 May] shows areas of [Mr A's] toes on left and right feet, this is not reflected in wound management plan, or progress notes. Diagram not signed (page 64).

- Progress notes for [10 May] indicate discussion re pain and amputation (not specified as to what is to be amputated).

- [15 May] progress notes indicate left foot has small area on each toe, right foot is deteriorating, refer to wound chart (page 59). Wound management chart simply states all wound dressings applied (page 77).

- Last progress note on [20 May] state that the foot has deteriorated, which foot is not determined (page 62).

Summary:

[Dr D] saw [Mr A's] toe for the first time [25 March] and charted GTN patches, when the resident was already known to have poor circulation and peripheral vascular disease. Without good circulation this treatment may not work. Doctor does not identify which foot, however nurses write left foot in notes, not right (progress notes, page 66).

There is much confusion in the progress notes as to which foot and toe the staff were referring to on each entry. Care assistants completed many dressings for [Mr A]. No accurate assessment of wound completed at any time. Two wound charts at one stage, condensed into one, not filled out completely at any stage. Inadequate care plan which gave no direction to care assistants as to how to care for [Mr A's] wounds. Despite [Mr A] continuously articulating he was in pain his feet were not regularly assessed by a registered nurse, taking into consideration he was also an unstable diabetic.

Did nursing staff properly manage the pain associated with [Mr A's] foot?

[Mr A] was administered Panadol as charted prn for pain, and paradex tds on treatment record (page 42). Unable to read (pages 430 – 433) medication signing sheet to see when given, however notes indicate both medications were given regularly.

Whether the paradex was given tds as prescribed is not clear. DHC and MST are also prescribed towards the end of [Mr A's] admission. These are documented on medication signing sheet with only one signature. As this is classed as a dangerous drug this should be administered by a registered nurse, and signed for correctly. I also note it is given in conjunction with Panadol.

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There is no pain assessment completed at any time during [Mr A's] admission. Morphine elixir has not been trialled before MST charted, to indicate how much morphine is required to relieve [Mr A's] pain (i.e. slow release MST).

The morphine is stopped and started as [Mr A] experienced hallucinations. Between January and May [Mr A] complained of pain often as indicated by the progress notes. Adequate pain relief was not prescribed until May.

[Mr A's] level of dementia made it difficult to assess his pain, however he expressed it was in his foot often.

The registered nursing staff did not adequately manage [Mr A's] pain in his foot.

In your response please also advise whether the policy and procedure at [the retirement village] concerning wound management and any other policies and procedures you consider relevant to these issues were adequate. If so, did staff comply with these?

- Wound Management – principles of (pages 455 & 456) as part of clinical services manual, outlines clearly policy and procedure.

- Dressing policy not available for critique.

- Page 456 clearly states that the management of a wound must be clearly documented in the nursing care plan by the registered nurse. This is not adequately achieved. Although [Mr A's] wound is stated on his care plan. The care plan refers on to the WMC (wound management chart). The wound management chart only documents a change of dressing and a brief description of the wound. This is inadequate for a diabetic resident with known peripheral vascular disease.

- No information is given as to the research behind GTN patches, as best practice for wounds. Care assistant staff completed documentation adequately for their scope of practice, although no clear indication in many entries in the progress notes as to which toe or foot is being referred to.

- Registered nurses should have assessed the wounds to [Mr A's] toes on a more regular basis, and documented their findings. The wound management chart is poorly completed and confusing as to which wound is being dressed with which product.

- A cocktail of wound products was used with no assessment as to why the products were changed, and no indication of which wounds were requiring which products. A separate wound management chart may have ensured clearly understanding or how each foot was being managed.

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- The registered nurse needed to take responsibility for these wounds as [Mr A] was known to have PVD and Diabetes.

- Medicine management is inadequate as pain relief prescribed not given as per medication chart and not signed accurately or legibly.

- Education on pain management is required for the registered nurse. It is also not clear who was administering the morphine.

Continence

Was [Mr A] incontinent? If so, at what point?

- There is no specific continence assessment completed on [Mr A] at any one time during the five months in question.

- Due to his increasing dementia this assessment would have been difficult to complete, however on admission when he was not so confused a baseline assessment may have assisted the staff to adequately care for his continence needs.

- Nursing assessment (page 21) indicates [Mr A] was continent on admission to this unit on [18 January].

- First indications of incontinence is documented in the nursing progress notes is the very next morning on the 19/01/02 (page 25). The next documented episode of incontinence is on the [5 February] at 0515 hours (page 28).

Did nursing staff properly assess, monitor and treat [Mr A's] level of continence and his inappropriate urination? If not, what should staff have done?

- There is no continence assessment completed at any time during [Mr A's] admission to this unit.

- Correspondence from [the Director of Nursing] indicates that the care staff considered him to be continent and that he was likely to urinate on the carpet. She also states that he had difficulty getting to the toilet as his walking was affected by the pain he was experiencing (page 6).

- [Mr A's] bed is padded with products and incontinent products were trialled on [26 April] (page 50) as indicated in the progress notes. The outcome of this trial is not evident.

- Incontinence is only mentioned on one occasion in the nursing care plan (page 909).

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- Regular reinforcement of the two hourly toileting regime may have increased [Mr A's] continence, but as he became less mobile his ability to get to the toilet diminished.

- Moving [Mr A] to a room without carpet would have assisted in the elimination of odour as he urinated on the carpet frequently.

- Inadequate assessment and documentation in the nursing care plan by the registered nurse makes it difficult to assess [Mr A's] incontinence.

It appears to the Commissioner that there is no evidence in the records that [Mr A] had scalding or skin irritation as a result of urination while at [the retirement village.] However, if you consider there is clinical evidence of this, please advise whether the scalding or skin irritation was properly assessed and treated by staff.

- No clinical evidence of scalding or skin irritation documented in the clinical notes as a result of urination. [Mr A] did not urinate often in his clothes but chose to use the carpet.

In your response please also advise whether the relevant policies and procedures at [the retirement village] concerning the issue of continence were adequate. If so, did staff comply with these?

- Continence: Management of urinary and faecal policy and procedure (page 445) clearly states that the resident will be assessed by the registered nurse and an individual programme developed with monthly evaluation. How this assessment will be completed is not outlined.

- A comprehensive continence assessment was not completed at any time for [Mr A].

- Incontinence aids were used, especially in the last six weeks of his admission.

- Care assistants documented episodes of incontinence in the progress notes.

- Policy and procedure is adequate however not carried out by the registered nurse.

- As [Mr A] had an ensuite in his room it was not difficult for care staff to toilet him on a regular basis.

Skin condition

Did staff appropriately assess, monitor and treat the condition of [Mr A's] skin? If not, what should staff have done?

- Nursing Admission (page 20) indicates 'facial skin can become dry'.

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- Skin treatments not outlined in nursing care plan (some parts are illegible due to poor quality of photocopying).

- Progress notes [22 January] indicates cream was applied to very dry face (page 26). Referral sent to dermatologist.

- [25 January] progress notes indicate dry skin (page 27).

- Seen by dermatologist and no further treatment required ([22 March]). No report (page 37).

- Progress notes for [29 March] indicate skin on face dry, moisturise BD.

- On [31 March] progress notes indicate face and scalp very dry. Alfa Keri lotion, shampoo and deodorant delivered by son and daughter in law.

- Progress notes for [2 April] indicate face dry, cream applied (page 41).

- No more entries re [Mr A's] dry skin. As his condition deteriorated the focus was on his blood sugar levels and wounds. Adequate treatment of dry skin to face as outlined in progress notes.

Should staff have referred [Mr A] to his general practitioner for further assessment? If so, at what point?

- General practitioner attended to [Mr A] on several occasions as his condition deteriorated. No further assessment of skin irritations required.

In your response please also advise whether the policy and procedure at [the retirement village] concerning skin integrity (pressure areas) and any other policies or procedures you consider relevant were adequate. If so, did staff comply with these?

- Skin integrity – Management of and risk to pressure area policy and procedures are adequate. The policy focuses on pressure areas. There is no assessment form as part of this policy (page 454).

Oral thrush

It appears to the Commissioner that there is no evidence in the records that [Mr A] had oral thrush while at [the retirement village]. However, if you consider there is clinical evidence of this, please advise whether this was properly assessed, monitored and treated by staff.

- There is no evidence of oral thrush in any documentation.

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General

Overall, did nursing staff appropriately respond to [Mr A's] deteriorating condition?

- The registered nursing staff at [the retirement village] were slow to respond to [Mr A's] deteriorating condition due to lack of registered nurse supervision of his diabetes, his feet and general condition.

- The care assistants delivered care to the best of their ability and overall documented adequately for their scope to practice. At times they could have been more specific with their descriptions in the progress notes outlining what they were doing with [Mr A's] wound care management.

- The weekly summary notes in the progress notes added no value to the overall management of [Mr A's] deteriorating condition and only gave general statements about his overall condition and no plan for ongoing management of his care.

- All staff caring for [Mr A] needed to be clear as to which wounds they were reporting on in the progress notes, as this is often not clear and confusing.

- [Mr A's] medication management was inadequate, inefficient and not within legal boundaries of good practice.

- No wound assessment, poor wound management chart, inadequate nursing care plan, all need updating and improving.

- Difficult to read progress notes, not always dated and signed, some parts illegible. Identification of staff members writing in progress notes not always clear.

- No indication that doctor's section was in fact a doctor's only section, not labelled as such.

- No continence assessment completed by registered nurses.

- Good contact documented with the family.

- [Mr A's] deterioration in his wound, leading to transfer to a public hospital was due to poor management of his overall medical condition. His dementia care needs were met, however his acute medical needs were not. There was a major failure on the registered nurses monitoring and supervision of his wounds, continence, pain and suffering.

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Are there any aspects of the care provided by nursing staff or other providers (including the general practitioner) involved in [Mr A's] care which you consider warrants either:

- ***Further exploration by the investigation officer?***
- ***Additional comment?***

No, covered within report."

Additional nursing advice
The following additional independent expert advice was obtained from Ms Wendy Rowe, registered nurse, in light of the responses to my first provisional opinion:

"Thank you for the opportunity to further comment on the above complaint. I have read and reviewed the information received:

1. Copy of the provisional opinion at pages 1–47.

2. Copy of the response from [the retirement village group] (including copy of independent nursing advice report from [Ms G], copies of letters from local medical staff and the podiatrist treating [Mr A], and copies of [the retirement village group] care policies) at pages 48–149.

3. Copy of clinical records at pages 150–468.

4. Copy of response to the facts gathered from [Mr and Mrs B] at pages 469–475.

[Mr and Mrs B's] response:

- [Mr and Mrs B] seem to have ongoing issues about [Mr A's] care. My report is based on the information available to me at the time and in no way compares with the relationship they had with [Mr A]. My report is based on a retrospective review of the documentation received pertaining to [Mr A's] admission to [the retirement village].

[The retirement village group's] response:

- My report dated 3 November 2003 is based on the information I received at the time. In light of the new information I have now received and reviewed, my provisional opinion may have been somewhat critical.
- I stand corrected about the administration of morphine sulphate. One of the two staff members who sign the controlled drug register should be a registered nurse. This is often unrealistic in a rest home environment. I understand that the medication-signing sheet only requires one signature.

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- There is no evidence of complex wound assessment by the registered nurses. The nursing care plan and wound management chart are not linked. The wound care policy was not available to me at time of writing my report.
- The progress notes are not assessment tools. They are there to document exceptions to the care plan on a shift by shift basis. The care plan is brief and does not indicate the complexity of the wounds.
- Continence assessments were completed but not available to me as indicated in the additional information reviewed. This information would have been appropriate to include. A comprehensive continence assessment completed by the registered nurse was necessary.
- Truly integrated progress notes where all health professional documented in chronological order on the same page would be beneficial.

[Ms G's] report:

- Written in October 2004 after interviewing the staff[8] and access to information I did not have available to me at time of writing my report.

- Recommended changes to the documentation surrounding medication management, integration of all progress notes, review of wound care charts.

- I do not dispute that the caregivers gave appropriate care to [Mr A].

- Good to note positive improvements made to areas of nursing practice in her report.

[Dr D]:

- None of my comments are directed at [Dr D], as this is not my job. The comments made about [Mr A's] medical condition and medical needs are pertaining to the registered nurses that were caring for him. The registered nurse is responsible for assessment and monitoring of the resident's medical condition and needs also. They are the ones who care for the resident on a daily basis. The only comment pertaining to [Dr D] is in relation to the use of GTN patches. This is in no way a reflection on his practice as this is not my intent to do so. My only comment was 'this treatment may not work'.

Is there anything in the new information provided by the parties that would cause you to alter your opinion as set out in your 3 November 2003 report?

[8] In their response to my second provisional opinion the retirement village group noted that Ms G did not interview the staff involved in Mr A's care, although I note the Director of Nursing at the retirement village group was interviewed on two occasions by Ms G during preparation of her report.

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- I stand corrected that the morphine administered to [Mr A] can be given by a caregiver in a rest home environment. Progress notes should not be used as pain assessment tools by the registered nurse that need to make their own assessments of residents. However not optimal, this does not reach the threshold of a major departure from the accepted standard of care and skill.

- The registered nurses at [the retirement village] used the progress notes as an assessment of the needs of [Mr A] instead of comprehensively making an independent written assessment that they then based their plan of care on. Their policies and procedures state that they deliver care which is based on assessment and care planning, yet they did not do this in practice.

- Although the policies and procedures were in place at the time of this event the registered nurses did not assess [Mr A] on a regular basis and this is not optimal practice. The registered nurses needed to ensure that the caregivers were well informed of the plan of care for [Mr A] on a weekly basis. There have obviously been some improvements since this event occurred.

- The registered nurses caring for [Mr A] may have assessed and delivered care to a reasonable standard without accurately documenting. Unless the registered nurses document what they do there is no way of evaluating the care accurately.

- Overall, given the new information I now have, in my opinion the registered nurses failed to meet the standard of care and skill reasonably expected when [Mr A's] condition deteriorated. This failure was minor, but would incur the moderate disapproval of other peers. It is good to see that the site has made progress towards improving care for residents."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) 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.

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RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
a) An explanation of his or her condition; …

Opinion: No Breach – The Rest Home Company

Mr A's care
Mr and Mrs B complained that the retirement village failed to provide appropriate care to Mr A while he was a resident in the Secure Unit. They raised a number of specific concerns, but overall felt that, as Mr A's health deteriorated, staff at the retirement village failed to respond appropriately or to keep them advised so that they could be meaningfully involved. They accepted that, as an elderly man with a number of health problems, his condition would deteriorate, but felt that the lack of communication and response from the retirement village group to his deterioration was inappropriate and distressing, both for Mr A and themselves. Specifically, they complained that Mr A's problems with his right foot and toes began prior to his admission to the unit in January, and that staff at the retirement village delayed treating the wound on his right foot properly until the foot and three of his toes became gangrenous and turned black. They also contend that staff did not properly manage the pain in Mr A's right foot, which was associated with its deteriorating condition. Further, they allege that staff did not treat the longstanding wax problem in Mr A's ears and his difficulties with continence, which resulted in scalding to his skin, and did not appropriately respond to problems with oral thrush and the skin condition on his face, head, ears, hands and arms.

Mr A's feet and toes
Mr A reportedly raised concerns, as did Mr and Mrs B, about pain in his feet from the previous August. As set out above, Mr and Mrs B allege these were largely ignored by the retirement village staff, and no planned and co-ordinated response was initiated until the deterioration of his right foot was well advanced.

In relation to documentation, Mr and Mrs B commented that "the fact that there was no record in notes about some of the things we complained about means that nothing can be done about them in the investigation. It suggests that what we say didn't happen."

My expert nurse advisor, Ms Rowe, also raised a number of concerns about the planning and documentation of Mr A's care at the retirement village. In particular, she noted no evidence of a comprehensive toe and foot assessment by registered nursing staff, lack of a planned and co-ordinated approach to foot management, lack of linking between the nursing

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care plan and the wound management chart, inaccurate and incomplete recording of foot assessment and wound dressings,[9] no evidence of the rationale for changes in management, and the use of progress notes and the wound chart rather than the nursing care plan to manage Mr A's foot ischaemia and advancing gangrene.

Ms Rowe was also critical of the lack of evidence of registered nurse oversight of the plan and care, noting that the impression left was that Mr A's nursing care was directed by the caregiver's assessment and documentation in the progress notes, rather than by a systematic, planned and consistent approach directed by registered nurses, whose expertise was required given Mr A's history of diabetes, PVD and escalating deterioration. Ms Rowe noted that "the progress notes are not assessment tools. They are there to document exceptions to the care plan on a shift by shift basis. The care plan is brief and does not indicate the complexity of the wounds." Further, "unless the registered nurses document what they do there is no way of evaluating the care accurately".

The retirement village group responded that the concerns raised by Mr A were addressed by staff when they were brought to their attention. They comment that Mr A's diabetes and PVD caused his right foot to break down more quickly and become gangrenous, but his deterioration and pain were properly managed by staff, in consultation with Dr D and Dr F (vascular surgeon). In particular, nursing staff regularly dressed the wound on Mr A's right foot, assessed his pain during dressings, appropriately liaised with Dr D, and administered pain relief medications as charted.

In response to my nurse advisor's criticisms, the retirement village group submitted that registered nurse oversight did take place, albeit informally,[10] that caregivers were directed in the care provided and the wound dressing changes required, and that all the information required to manage Mr A's foot wounds was available. The retirement village group acknowledged that the nursing care plan did not specifically detail the day-to-day treatment of Mr A's foot dressings, but stated that the nursing care plan referred the nurse/carer to the wound management chart, which directed and plotted the care given to Mr A. This was considered best practice in the unit, where care needs can change frequently, and avoided reproduction of information. Further, the retirement village group commented that the proposed "adverse finding against the retirement village seems to be primarily based on the notion that alleged inadequate or insufficiently detailed documentation and record-keeping equates with inadequate nursing care. Clearly enough it does not."

The retirement village group submitted that appropriate measures were put in place to address concerns about Mr A's foot, and that the deterioration was inevitable and resulted from his condition, and not from suboptimal care. Further, while all communication regarding care was not documented, the care provided was appropriate.

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[9] See the inaccuracies noted in the report of my nurse advisor.

[10] The retirement village group advised that the registered nurses and the principal nurse manager communicated verbally with each other as to what was required in terms of wound management.

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My expert general practitioner advisor, Dr Carey-Smith, noted that Mr A's longstanding insulin-dependent diabetes was probably responsible for his progressive PVD, which was the cause of the problems with his right foot and toes. The PVD inevitably resulted in ischaemia (which initially presented in July the previous year as dry feet with corns) and later gangrene developed, as often occurs. Dr Carey-Smith stated:

> "I can think of no other measures that could have delayed deterioration or improved pain and suffering to [Mr A]."

My advisor noted that ischaemia and diabetes increase the risk and delay in the healing of any wound or ulcer that develops, because of the poor blood supply and reduced immune response. Mr A's age (88), poor general health and previous smoking are also likely to have affected the condition and response to treatment of his feet and toes. Dr Carey-Smith said that even if the peripheral vascular insufficiency had been detected earlier, "it is unlikely that any measures could have averted the inevitable deterioration".

Based on all the available evidence I am satisfied that Mr A generally received good nursing care.[11] However, in relation to the management of Mr A's deteriorating foot condition and the subsequent development of gangrene in his right foot, I am left with some doubts. While I accept that in itself, lack of documentation does not equate to lack of care, good nursing care is guided by clear, ongoing assessments and a plan of care. Nursing assessments and the care plan should be properly documented, available to all staff, and updated as a patient's needs change. I do not accept that verbal discussions on an 'ad hoc' basis are adequate. In this regard, I concur with my nursing advisor, who commented that comprehensive toe and foot assessment by registered nursing staff, together with a planned and co-ordinated approach to foot management and accurate and complete recordings of foot assessment and wound dressings on the nursing care plan to manage Mr A's wounds, would have been optimal.

Furthermore, the retirement village group's own policies in respect of nursing care plans and documentation were not complied with. If, as is suggested by the retirement village group's submission,[12] the retirement village's policies do not reflect the reality of everyday practice, either the practice or the policies should be changed.

Overall, while I accept that Mr A's complex medical condition, history and age were the main causes of the deterioration of his feet and toes and his lack of response to treatment, I

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[11] In this regard, the retirement village group have provided me with supporting letters from a number of doctors with experience of the retirement village, including Dr D, who treated Mr A, all of which comment that the standard of nursing care at the retirement village at the relevant time was good. Ms C, Mr A's daughter, has described Mr A's care as excellent.

[12] For example, the retirement village group has provided evidence of a nursing care policy that states that "plans are actively used to guide the delivery of care". However, in their response to this complaint, the retirement village group has advised that, to avoid reproducing information, wound care is directed through the wound management chart.

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consider that the nursing care of Mr A's feet and toes would have benefited from clearer planning and documentation. I do not, however, find that these shortcomings by the retirement village amount to a breach of Right 4(1) of the Code.

Pain management
Mr and Mrs B were concerned that the retirement village group's response to the pain associated with the deterioration of Mr A's feet was not appropriately managed.

In response, the retirement village group advised me that Mr A's pain was properly managed by staff, in consultation with Dr D. They submit that staff were vigilant regarding Mr A's pain levels, and that Dr D was contacted appropriately and regularly and was kept well informed about pain-related issues.

The records do not indicate that a comprehensive pain assessment was ever undertaken by nursing staff, as is required by their policies in respect of pain management. The retirement village group advised me that Mr A's pain was difficult to assess in view of his dementia. This view is supported by the advice of both my nursing and general practitioner experts.

The medication charts do, however, indicate that nursing staff regularly administered appropriate pain relief (as required) to Mr A, particularly from late March when his pain increased significantly. Further, there are frequent records of pain, particularly during wound dressings, which were reported and responded to, by both nursing staff and Dr D. Specifically, the records indicate a step-up approach to pain management, commencing with paracetamol, then stronger opiates (DHC), then strong (morphine), all prescribed regularly, and balanced against the side effects of drowsiness, increased risk of immobility and falls, reduced fluid intake and chest infection.[13]

In the view of my general practitioner expert, "there were no other measures that could have improved Mr A's pain and suffering". In contrast, my nursing advisor was initially critical of the management of Mr A's pain and the documentation of pain relief administered by the retirement village staff. Having viewed further information and submissions from the retirement village group, Ms Rowe remained of the view that a comprehensive pain management assessment documented in the nursing care plan, rather than the use of progress notes as the primary assessment tool, would have been appropriate. However, she acknowledged that Mr A's pain was managed appropriately in consultation with Dr D, and pain medication administered and documented in accordance with legal requirements.

In these circumstances, I do not consider that the management of Mr A's pain by the retirement village amounts to a breach of the Code. In my opinion, staff appropriately managed Mr A's pain in consultation with Dr D, and altered his medication as indicated by his increasingly frail state, confusion and falls. However, I would encourage the retirement village group to reflect on its policies and practice and, as noted above, if the policies do not

[13] As noted by my medical advisor.

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reflect the reality of everyday practice at the retirement village, either the practice or the policies should be changed.

Continence management and scalding
Mr and Mrs B raised concerns about continence management – specifically, they were concerned that Mr A was often found in wet or drying clothing and that his room smelt continuously of stale urine. They also advised me that Mr A had experienced urine scalding.

The retirement village group responded that Mr A was not incontinent, but that as a result of his dementia he often urinated in inappropriate places. Further, the retirement village group submitted that this was not an uncommon problem in dementia patients, but was very challenging behaviour to manage. They advised me that, despite regular toileting, the use of continence products and a uridome, they had not been successful in preventing Mr A from urinating in inappropriate places. Appropriate measures had been put in place to regularly monitor and address the smell of stale urine, which included carpet cleaning of the unit. However, a smell of urine can permeate carpet even when rigorous cleaning regimes are undertaken. The retirement village group noted that there were numerous recorded occasions when staff changed Mr A's clothing. There was no evidence in the medical notes of the retirement village, the public hospital, the hospice or the private hospital that Mr A experienced long-term scalding.

I note that the retirement village group policies require a continence assessment where issues with continence arise. The retirement village group have advised that a continence assessment was conducted at the time of Mr A's admission to the unit and he was recorded as continent. While there were clearly ongoing issues with continence, the retirement village group asserts that Mr A's problem was "inappropriate urination" rather than incontinence.

My nursing advisor commented that the urinary incontinence policy did not appear to have been followed and there did not appear to be a planned and coordinated approach to continence management. Again, she was concerned that there was no comprehensive assessment (in respect of continence) documented in the nursing care plan, to show changes to care based on ongoing and regular monthly evaluation, with the rationale for any changes documented.

It is clear that it was very difficult to manage Mr A's continence needs (and the resulting urine smell) in light of his rapid physical and mental deterioration, despite significant attempts by nursing staff. While my nursing advisor was critical of the lack of a planned approach to continence management, she did acknowledge that the "policy and procedure is adequate". Further, she noted that there is no evidence in the clinical documentation (including the records of the public hospital, the hospice and the private hospital) that Mr A developed scalding or skin irritation as a result of urination at the retirement village.

In these circumstances, I do not consider that the management of Mr A's continence by the retirement village amounts to a breach of the Code. In my opinion, staff took appropriate steps to manage Mr A's urinary habits albeit unsuccessfully. However, I would encourage

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the retirement village group to reflect on its policies and practice and, in particular, its use of the nursing care plan to document a comprehensive assessment, regular, ongoing evaluation and resulting changes to the plan of care in response to a patient's changing needs. There is a risk that information will be missed if it is buried in the progress notes. If the policies do not reflect the reality of everyday practice at the retirement village, either the practice or the policies should be changed.

Skin care

Mr and Mrs B also raised concerns about the management of Mr A's skin. Specifically, they were concerned that Mr A developed a skin condition, red lesions the size of a 20 cent coin on his face, head, ears, hands and arms, and that despite the fact that he shed skin as he walked, the retirement village group's staff failed to respond appropriately to this.

The retirement village group responded that nursing staff adequately managed the dry skin on Mr A's face and scalp. They acknowledge that Mr A was recorded as suffering a number of skin conditions, including skin keratoses and dry skin, but note that these were treated appropriately and referrals to Dr D and a dermatologist were initiated as appropriate. Staff regularly applied moisturiser to his face and applied the products supplied by Mr and Mrs B. They also note that on 22 March Mr A was assessed by a dermatologist, who advised that his skin seemed to be in "reasonably good condition" and discharged him from the clinic. The retirement village group comment that there is no documented concern about the condition of Mr A's skin (on any part of his body) in the retirement village records after 3 April, although he received a slight graze to the top of his head and skin tear on his left elbow as a result of falls. There is also no documented concern about the condition of Mr A's skin in the public hospital records (apart from his elbow and shin).

The nursing progress notes indicate that Mr A did have a problem with dry skin, which was addressed as required by the use of facial moisturiser. My nurse advisor commented that, although there were few entries about Mr A's skin, there was adequate treatment of his dry skin documented in the progress notes. It is also of note that, while the nursing staff at the hospice recorded on 23 May that Mr A had "multiple patches of mefix ?abrasions", it seems most probable that these "?abrasions" occurred as a result of his recent falls at the retirement village, rather than as a result of poor attention to a skin condition. In this regard, I also note the advice of my medical advisor that Mr A's dry skin was managed by the nursing staff and that, in respect of the monitoring of the skin for malignant change, infection or diabetic complications, there is no evidence that Dr D's role as GP was not carried out satisfactorily. Further, I note that the private hospital nursing admission form stated on 30 May that Mr A's skin was in good condition apart from his feet.

In these circumstances, I find that Mr and Mrs B's allegations that Mr A's skin management was poor are not substantiated and accordingly there is no breach of the Code.

Oral thrush

Mr and Mrs B alleged that Mr A had oral thrush that was not recognised or treated while he was a patient at the retirement village – specifically, that Mr A developed severe *Candida*

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albicans in his mouth. They questioned whether the oral thrush was ever treated at the retirement village.

The retirement village group responded that there is no indication in the records that Mr A experienced oral thrush during the period when he was in the unit.

There is no evidence in any of the clinical documentation (including the records of the public hospital) that Mr A had oral thrush in the unit or on his transfer to the public hospital. My nursing expert also notes that "there is no evidence of thrush in any documentation". In my view, which is supported by my medical advisor, it is probable that Mr A developed oral thrush on admission to the hospice where he was prescribed Nilstat for a "constant red/dry mouth". The thrush is likely to have resulted from his poor condition, antibiotics or his diabetes.

In these circumstances, I find that Mr and Mrs B's allegations that Mr A had *Candida albicans* that was not treated at the retirement village are not substantiated and accordingly there is no breach of the Code.

Communication
Mr and Mrs B allege that they were kept very much "in the dark" over matters concerning Mr A's condition, despite the fact that Mr B held an enduring power of attorney over his father's personal care and welfare (the front page of the clinical notes form recorded that Mr B had power of attorney over "property and health"). They visited Mr A either alone or together eight times during his residence in the unit. They accept that Mr A was likely to deteriorate. However, they are concerned that they were not kept informed about Mr A's condition, particularly his deterioration, by nursing staff at the retirement village.

The retirement village group responded that nursing staff comprehensively discussed the care and treatment of Mr A's management with both Mr and Mrs B. The nurse manager of the unit stated that she sometimes found it difficult to contact Mr B, as he worked at night, but she had a number of meetings of an "impromptu/informal nature" with Mrs B. The retirement village group also advised that, in particular, when Mr A's right foot began to deteriorate they initiated contact with Mr and Mrs B, who also had contact with Dr D and the vascular surgeon, Dr F, to discuss ongoing management. The retirement village group do not accept that their communication was inadequate.

My nursing expert considered that overall the contact nursing staff had with Mr and Mrs B about Mr A's condition was good. This view is supported by the advice of my medical advisor, who noted that Dr D and nursing staff at the retirement village appeared to have a close working relationship and communicated when necessary with Mr A's relatives. Dr Carey-Smith acknowledged the apparent difficulties of regular face-to-face communication because of the geographical distance between Mr and Mrs B's residence and the retirement village and commented that "determining the frequency of phone contact and visits is always difficult in this situation, for relatives as well as for GP and rest home staff" but concluded

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that the "teamwork and communication between [the retirement village] and [Dr D] was excellent".

Nursing staff at the retirement village were obliged to keep Mr B informed about his father's condition because he held an enduring power of attorney in respect of his father's personal care and welfare. As attorney, he was entitled to the same information as his father (while incompetent) under Right 6 of the Code, because the definition of "consumer"[14] includes a person entitled to give consent on behalf of that consumer. Mr B was able to give consent on behalf of his father pursuant to the power of attorney. I am satisfied that Mr A was mentally incompetent when he was admitted to the unit in January or shortly thereafter, in light of his deteriorating mental condition.

I am satisfied that Mr and Mrs B were adequately informed about Mr A's deteriorating condition during March and April and that this was a responsibility that was shared by all providers involved in Mr A's care. Mrs B was informed on 26 March about Mr A's right foot and toe problems. Mr B was similarly informed on 5 and 9 April. Dr D documented discussions with Mr and Mrs B about his care of Mr A, escalating in frequency as Mr A's condition deteriorated. I also accept that Mr and Mrs B were adequately informed about the options for Mr A's treatment following their meeting with Dr F on 24 April.

The nursing progress notes record: "Family will be advised of deterioration to feet with with increase in pain and its management" (8 May). An entry on 10 May states: "Update to family – [Ms E] discussed and explained current health status and progress of ongoing pain and amputation. Family contact took 2 days due to the difficulties with contacting Mr B." An entry on 12 May states: "[Dr D] will update next Monday with family." An entry on 19 May states: "Phoned [Mr B] (son) for update with [Mr A], and to notify him of recent incidents (falls) and that [Dr D] will make contact with family on Monday lunch time." It is therefore reasonable that a member of the multidisciplinary team made contact with the family on at least four occasions during May, namely on Friday 10 May, Monday 13 May, Sunday 29 May, and the following Monday 20 May.

I acknowledge that staff at the retirement village sometimes contacted only Mrs B about Mr A's condition. However, in my view it was reasonable to assume that any important information would be given to Mr B by his wife. I note, however, that the Code does not prevent providers from keeping family members informed and advised when their relatives are receiving care.

I accept that Mr and Mrs B, who lived in one city while Mr A was in the unit at the retirement village in a city three hours distant, did not feel adequately communicated with, particularly as Mr A's condition deteriorated. However, there is evidence of regular

[14] See clause 4 of the Code of Health and Disability Services Consumers' Rights.

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communication and I accept the advice of my nursing and medical advisors that communication by the retirement village staff was adequate. In these circumstances, I do not consider that there was a breach of the Code.

Opinion: No Breach – Dr D

Medical management
Mr and Mrs B allege that Dr D failed to manage Mr A's medical needs appropriately and, in particular, did not respond appropriately to the deteriorating condition of Mr A's right foot and toes and manage his associated pain. They also allege that Dr D tried to persuade them (inappropriately) to agree to the amputation of Mr A's right leg. Further, they allege that Dr D did not properly respond to the condition of the skin on Mr A's face, head, ears, hands and arms.

Dr D responded that he appropriately assessed and treated Mr A's right foot and toes by responding promptly to requests by the retirement village to assess Mr A's toe and feet, requesting laboratory tests (for example, wound microbiology), prescribing antibiotics and referring Mr A to Dr F for assessment when the condition of his feet and toes failed to respond to local measures. Dr D stated that he also increased Mr A's pain relief appropriately in accordance with a progressive step-up approach, moving from Panadol to DHC to morphine as Mr A's pain increased. He carefully monitored him for side effects, and responded appropriately when they were recorded and brought to his attention. He commented that it became increasingly difficult to care adequately for Mr A in the unit because his fluid intake fell and he had progressive confusion. Dr D further stated that Mr A's overall physical condition probably deteriorated in May because of the toxins from the gangrene of his right foot and the effects of his pain relief, rather than suboptimal care.

Dr D stated that there is no evidence in the records of the GPs who assessed Mr A, prior to his transfer to the unit, that he had developed skin lesions.

My general practitioner advisor, Dr Carey-Smith, advised that Dr D adequately responded to Mr A's deteriorating condition. In particular, Dr D:

- appropriately reviewed Mr A's condition every three months when it was stable;
- assessed in a timely manner the condition of Mr A's right foot on 25 March after he was advised by nursing staff on 21 March of their concern;
- properly monitored and responded to the deterioration in the condition of Mr A's right foot after his initial assessment on 25 March;

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- could not have prevented and took appropriate measures (particularly the prescription of antibiotics) to delay the usual progression from ischaemia to frank gangrene in relation to Mr A's right foot.[15]
- referred Mr A in a timely manner for an assessment of his right foot by Dr F on 8 April after local measures (for example, wound treatment) and systemic antibiotics had failed to reverse the deterioration;

- appropriately managed the pain in Mr A's right foot by progressively and regularly prescribing Panadol and opiates (DHC and morphine). Dr D also properly took into account the risk of side effects from these medications. I also note Dr Carey-Smith's advice that pain management in elderly patients, particularly with dementia, is complex and difficult, because their pain has to be assessed indirectly, for example by their reaction to dressing changes;

- referred Mr A in a timely manner to the public hospital for assessment and treatment on 20 May, which resulted in his admission;

- properly monitored the condition of the skin on Mr A's face for signs of malignant change, infection or diabetic complications.

I accept the advice of my medical expert. As set out above, Mr A's complex medical condition, history and age were the major causes of the deterioration of his right foot and toes and lack of response to treatment, rather than suboptimal medical care. In my opinion, Dr D regularly monitored Mr A's condition,[16] prescribed antibiotics and appropriately referred Mr A to Dr F (vascular surgeon). I also note Dr Carey-Smith's advice that Dr D properly managed Mr A's pain relief, which was complex, and appropriately increased the potency of the pain relief medication in response to progressive pain, carefully balancing this with reported side effects.

I further accept Dr D's explanation that he did not attempt to persuade Mr and Mrs B to agree that Mr A's right leg should be amputated below the knee; rather, he genuinely believed that better pain management would be achieved by taking up this option. I also note that Mr and Mrs B were aware of alternative treatment options, in light of their discussions with Dr F on 24 April.

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[15] I accept Dr Carey-Smith's advice that Mr A's response to antibiotics was slow because of his poor blood supply and reduced immune response caused by his diabetes and PVD. Mr A's age, poor general health and history of smoking are also likely to have impacted on his condition and response to treatment of his right foot.

[16] Three-monthly visits, as is legally required, were recorded by Dr D, with increasingly frequent visits and ongoing assessment throughout the latter part of March, throughout April and May, until Mr A's transfer to the public hospital on 20 May.

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Skin management was also adequately monitored in the opinion of my medical advisor. Accordingly, in respect of the medical management of Mr A, I do not find Dr D in breach of the Code.

Communication
Mr and Mrs B allege that they were kept very much "in the dark" over matters concerning Mr A's condition, despite the fact that Mr B held an enduring power of attorney in respect of his father's personal care and welfare. They accept that Mr A was likely to deteriorate. However, they were concerned that they were not kept informed about Mr A's condition, particularly his deterioration, by Dr D (and staff at the retirement village). Mrs B recalled that Dr D did not contact her by phone prior to 20 May, when Mr A was admitted to the public hospital, or leave a message. Mr B could not recall such contact.

Dr D responded that he communicated adequately with Mr and Mrs B and noted mention of communication between himself, the retirement village staff and Mr and Mrs B, increasing in frequency as Mr A's condition deteriorated,[17] culminating in his admission to the public hospital on 20 May. Dr D said that he often made phone calls to Mr and Mrs B and suggested meeting them at the unit. On some occasions he was only able to get their answering machine. Dr D said that he informed Mrs B immediately prior to Mr A's admission to the public hospital on 20 May that his foot was worsening.

Dr D, like the nursing staff at the retirement village, was obliged to keep Mr B informed about his father's condition because he held an enduring power of attorney over his father's personal care and welfare.

The perception of Mr and Mrs B as to adequate communication conflict with the recollection of Dr D and the retirement village staff. As my medical advisor commented, "determining the frequency of phone contact and visits is always difficult in this situation, for relatives as well as for GP and rest home staff". Dr D and nursing staff at the retirement village appeared to have had a close working relationship and communicated when necessary with Mr A's relatives. Dr Carey-Smith acknowledged the apparent difficulties of regular face-to-face communication because of the geographical distance between the Mr and Mrs B's residence and the retirement home, but concluded that the "teamwork and communication between [the retirement village] and [Dr D] was excellent".

I am satisfied that Mr and Mrs B were adequately informed about Mr A's deteriorating condition during March and April and that this was a responsibility shared by all providers involved in Mr A's care. Mrs B was informed on 26 March about Mr A's right foot and toe problems. Mr B was similarly informed on 5 and 9 April. Dr D documented discussions with Mr and Mrs B about his care of Mr A, escalating in frequency as Mr A's condition

[17] Communication is noted on 21 January, 27 and 28 February, 26 and 31 March, 1, 5, 8, 9, 19, 20, 21, and 23 April, 10, 13, and 19 and 20 May.

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deteriorated. I also accept that Mr and Mrs B were adequately informed about the options for Mr A's treatment following their meeting with Dr F on 24 April.

Clearly, Mr and Mrs B did not feel adequately communicated with, particularly as Mr A's condition deteriorated. However, based on the advice of both my nursing and medical advisors, Dr D's communication with Mr and Mrs B was adequate. In these circumstances, I do not consider that there was a breach of the Code.

Other comments

Condition of Mr A's feet prior to his admission to the unit
Mr and Mrs B stated that Mr A complained about a sore toe prior to his admission to the unit in January. The studio notes record that on 7 July in the previous year Mr A complained of sore feet, which appear to have been relieved by a change in his footwear. Mr A also complained of sore feet on 27 August, and an area on the toe of his right foot was assessed by a podiatrist on 12 October. My medical advisor, Dr Carey-Smith, noted that the ischaemia on Mr A's right foot initially presented as "dry feet/corns" at his consultation with Dr D on 27 October.

The nursing assessment, which was undertaken on admission to the unit, did not record any concerns about the condition of Mr A's feet. The assessment recorded only that his medical diagnoses were diabetes and short-term memory loss and that he could fall on uneven ground. I accept that, in hindsight, the nursing assessment could have been more thorough and explicit about the condition of Mr A's feet, particularly in light of his insulin-dependent diabetes. However, at that time, the key presenting problem was Mr A's rapid mental deterioration, which was the primary reason for his admission to the unit. I also note that the registered nursing staff in the unit assessed Mr A's right foot on 2 March after his initial complaint of pain, and referred him to a podiatrist for assessment on 14 March and to Dr D on 21 March.

Policies and pain management protocol
The registered nursing staff at the retirement village did not comply with the following policies and pain management protocol:

- The treatment plan for dressing Mr A's feet and toe wounds was not clearly documented in the nursing care plan or the wound management chart by a registered nurse, as required by the policy on dressings. My nursing expert commented that the wound management chart did not provide sufficient direction to non-registered nursing staff. In response to my first provisional opinion the retirement village group stated that the wound management chart was sufficiently comprehensive to direct the actions of non-registered nursing staff involved in the management of Mr A's feet and toes; further, that "this is common and well accepted practice in the residential care industry and nursing practice". However, my nurse advisor did not

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agree, maintaining that complex wound assessment does not appear to have been completed, and that the nursing care plan and wound charts were not sufficiently linked. I concur. As noted above, if policy does not reflect everyday practice, then either the policy or the practice needs to be changed.

- The pain management protocol required that a resident's pain be assessed and monitored by using the resident orientated pain assessment scale and questionnaire, and that a pain control programme be entered into the nursing care plan by a registered nurse. The retirement village group's pain management protocol stated that if a resident was unable to express his or her level of pain, there needed to be an evaluation through the observations of registered nursing staff. The findings were required to be recorded on a pain chart. In response to my first provisional opinion, the retirement village group acknowledged that the pain management protocol did not specify a linkage to the wound management chart, where pain assessment during dressings was documented. The retirement village group stated that "the documentation of pain on a wound management chart was considered to be the pain chart for a wound at the retirement village". Once again, if policy does not reflect everyday practice, then either the policy or the practice needs to be changed.

- The type of uridome used to assist Mr A with his continence was not documented in the nursing care plan, as required by the retirement village policy on uridomes.

The above policies and protocols are clearly intended to ensure regular evaluation and oversight of a resident's care by registered nursing staff. However, the reality of practice at the retirement village reflected a different scenario where a significant amount of Mr A's care was directed through the progress notes. This view is supported by the retirement village group's own statement in relation to pain management that "the progress notes are used extensively in this unit and considered the most appropriate and effective way of communicating the multiple and complex needs of residents". This practice is inconsistent with the retirement village's policy on nursing care plans, which state that plans are "actively used to guide the delivery of care" and that only "significant changes" are to be recorded in the progress notes. I do not accept that it was appropriate to use the progress notes so extensively to direct Mr A's care. His complex needs, rapid deterioration, and need for the specialised services provided in the unit made Mr A at risk of discontinuity of care because of the fragmentary nature of the clinical information and the number of different providers[18] involved in Mr A's care. As my nurse advisor commented, "Truly integrated progress notes where all health professionals documented in chronological order on the same page would be beneficial." I note that this is a view also expressed by Ms G, who provided an independent report to the retirement village group.

[18]Including nursing staff, medical staff, podiatrist and a specialist vascular surgeon and dermatologist.

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Controlled drugs register
My nursing expert expressed concern that staff administered MST and dihydrocodeine (DHC) to Mr A without recording this in a controlled drugs register. As stated earlier, the retirement village group subsequently provided me with a copy of the controlled drugs register relating to the administration of MST to Mr A, which complied with the legal requirements for the administration of controlled drugs.

DHC was administered only once to Mr A (6 May) and then withheld because of concern about his health and stopped by Dr D on 7 May. The retirement village staff were not obliged to record the administration of DHC in the register, because it is a Class C controlled drug under Schedule 3 of the Misuse of Drugs Act 1975, and is exempted from complying with Part 6 of the Misuse of Drug Regulations 1977 (which require a controlled drugs register) by Regulation 48.

Documentation
Keeping accurate records is an essential element of the provision of health care. It assists in maintaining the quality and continuity of care. I draw the attention of the retirement village and the retirement village group to the comments of my expert nursing advisor concerning the need to clearly identify and document interventions. As my nurse advisor commented, "Unless the registered nurses document what they do there is no way of evaluating the care accurately." Particular attention should be paid to the need to identify the staff documenting the records and to clearly identify what area/side of the body they are managing in respect of wound management.

Recommendations

I recommend that the rest home company take the following actions:

- Review nursing care and policies at the retirement village in light of this report.
- Take appropriate steps to ensure that nursing staff at the retirement village are trained in, and compliant with, relevant policies.

Follow-up actions

- A copy of this report will be sent to the Ministry of Health Licensing Section.
- A copy of this report, with details identifying the parties removed, will be sent to Residential Care New Zealand Inc and the Retirement Villages Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix 1

Chronology of events

18 January
Mr A was admitted to the unit.

19 January
Staff in the unit recorded that Mr A was confused, incontinent of urine and required a reminder to dress, but was otherwise independent with his cares and eating.

21 January
Staff recorded that Mrs B phoned to ask about Mr A's progress.

22 January
Mr A's face was recorded as very dry and staff applied cream.

25 January
Mr A was noted to be very pale, extremely confused and unsteady on his feet. His blood sugar levels were recorded as 2.1 millimoles per litre (which is low) and he was given a sweet drink and a banana, which improved his condition. Staff were requested to encourage Mr A to eat between meals and to provide him with a banana each night.

Staff noted that Mr A had a rash on his face and the back of his neck. His skin was very dry and scaly and appeared to be aggravated by shaving.

26 January
Staff applied moisturiser to Mr A's face and noted that it was improving.

27 January
Staff recorded that Mr A's face was looking much better.

29 January
It was recorded in Mr A's nursing care plan (sometimes referred to in the records as a hospital care plan) that he had "dry facial skin".

3 February
An incident report form recorded that staff detected a skin tear on Mr A's left elbow, which was cleaned and dressed.

5 February
Mr A was incontinent of urine. The weekly nursing summary in the progress notes noted that Mr A's blood sugar levels were not well balanced and he required encouragement to eat more food late in the afternoon. Staff contacted Dr D, who prescribed glucagon intramuscularly (in case of severe hypoglycaemic reactions), and Protaphane (insulin) 20 units in the morning and 14 units in the afternoon.

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Mr A also received a three-monthly review of his condition from Dr D, who recorded his mental status quotient as 5/16. He noted his diabetic status and checked his general health status, which was ticked as satisfactory. Bloods were ordered. He recorded that Mr A commented that he was slightly unsteady on his feet when standing, and noted that although he had not experienced any falls he should use his stick. Dr D noted that both Mr A's feet were satisfactory.

8 February
During the night Mr A got up and appeared very confused. Staff provided him with a banana, a sandwich and cordial, which improved his condition. Staff also recorded that Mr A was incontinent.

10 February
An incident report form stated that the skin tear on Mr A's elbow (noted on 3 February) had healed.

14 February
The carpet in Mr A's bedroom was wet and staff were requested to observe if he was incontinent of urine and document all their findings.

15 February
Mr A was incontinent of urine and his pyjama pants and underwear were very wet.

18 February
The nursing staff recorded that Dr D assessed Mr A's diabetes recordings and decided to continue with the same insulin procedures.

27 February
Mrs B discussed with staff what action to take if Mr A suddenly deteriorated.

28 February
Mrs B phoned and requested that a "non-resuscitation protocol" be noted in Mr A's chart. Mrs B was requested to put this in writing.

2 March
Mr A complained that his right foot was very painful. Staff noted that his second and third toes were red, hot and painful when touched. His second toe had a corn. The nail of Mr A's third toe had been cut very near to the flesh and there was a black area in the right corner of the nail, "? blood". Staff were advised to monitor the condition of his feet.

11 March
Mr A was noted to have a corn on the side of his right foot and "? bruise" on the tip of his middle toe. He was assessed by a registered nurse, who debrided the corn, pierced the toe and removed a small amount of blood.

The weekly summary stated that Mr A's blood sugar levels were still fluctuating but seemed to be improving with snacks at night.

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14 March
A podiatrist removed the nail from Mr A's "toe" and dressed it.

15 March
Mr A was reported as urinating on the carpet in his bedroom.

Staff made an appointment for Mr A to be assessed by a dermatologist to check a lump on his head.

18 March
Staff were requested to assess Mr A's right foot as he complained of a lot of pain and his feet appeared red and were sore when touched. The third toe on his right foot also required attention. Staff were also requested to be familiar with the usual state of Mr A's feet, as his circulation was impaired owing to his diabetes. They were requested to report any changes in condition and ensure that Mr A wore soft shoes.

Mr A's nursing care plan recorded an "area on [Right] foot – see WMC [wound management chart]". Staff were also requested to observe Mr A's feet daily, as they might deteriorate.

21 March
A new dressing was applied to the third toe of Mr A's left foot. Staff requested that their colleagues report daily on the condition of his feet.

22 March
Mr A was assessed by a dermatologist at the public hospital, who wrote to Dr D and stated that Mr A's skin seemed to be in "reasonably good condition" and discharged him from the clinic.

23 March
Staff recorded that Mr A's left toe was very moist around the wound. Staff were requested to keep this dry.

24 March
Mr A complained of a very sore toe on his left foot.

25 March
Dr D assessed Mr A and noted that he had a sore third toe and took a swab (staff at the retirement village recorded that Dr D assessed Mr A's "left" foot). Dr D, in view of Mr A's poor circulation and PVD, prescribed Paradex (for pain relief) two tablets three times a day for 10 days, Synermox (an antibiotic) 250 mg twice a day for 7 days, and the use of GTN patches twice a day (to improve peripheral circulation on his foot).

Staff recorded that a GTN patch was to be applied to Mr A's foot at 8.00am and removed at 8.00pm and that he should wear a large bandage and soft sheepskin shoes day and night. His bed was to be fitted with a cradle, and the bandage replaced if wet.

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Staff were requested to place a bucket in Mr A's bedroom with a towel underneath so that he could urinate at night, and to observe and report the results.

The laboratory reported that Mr A's left foot wound had a heavy growth of *Staphylococcus aureus.*

26 March
Mr A was reported as very unsettled and his foot was very sore. Staff discussed with Mrs B the assessment by Dr D on 25 March. Mrs B was informed of the circulation problems in Mr A's feet and the area on his toe, caused by his longstanding diabetes. They also discussed Mr A's antibiotics, GTN patches, dressings, wearing of boots and "inappropriate toileting" in his room, which resulted in his foot becoming wet with urine. Staff advised Mrs B that Mr A would require wide soft footwear if he discarded his boot.

Mr B wrote to Dr D and stated that "there is to be no resuscitation or treatment of any type or degree to be taken".

28 March
Staff reported that Mr A's foot dressing was wet with urine and required redressing. It was also recorded that Mr A had been sleepy the past two days, so staff were instructed to try to reduce his Paradex to twice daily. In the evening a pad was placed on his foot to prevent urine wetting his dressing.

The weekly summary stated that the wound on Mr A's toe was checked by Dr D and was fine. Mr A's sugar levels were still fluctuating but his eating and blood sugar levels were being monitored.

It was recorded in Mr A's nursing care plan that "incontinence in room an issue".

29 March
Mr A's wound was noted to be improved and much drier. However, the skin on his face was very dry and needed moisturising twice a day. In the evening Mr A complained of pain in his foot.

31 March
Mr A's toe wound was redressed and noted to be a little moist. The skin on his scalp and face was very dry. Mr and Mrs B brought in a bottle of Alpha Keri lotion to treat the skin condition on his face.

1 April
Mr A's toe was redressed as the bandage was very wet with urine. There was no improvement in his wound. Mrs B rang to see how Mr A's toe was progressing. Night staff were requested to toilet Mr A every two hours.

2 April
At 5.30am Mr A's sheepskin boot was noted to be very wet with urine, although his dressing was dry. Later his dressing was noted to be wet and was replaced. Mr A was very

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sleepy after breakfast but became much more alert after morning tea. His Paradex was withheld at lunchtime. Mr A's face was very red and dry, and cream was applied.

In the evening Mr A was extremely confused and kept taking off his bandage.

3 April
Mr A was reported to have been sleepy after breakfast and his Paradex was withheld at lunchtime. Staff applied cream to Mr A's face, which was noted to be improving. He also had a small skin tear on the top of his foot.

The weekly summary stated that Mr A's face appeared to be very dry and cream was applied frequently. His blood sugar levels were being monitored between meals.

4 April
A registered nurse, who was called to the unit to assess Mr A, recorded that his left toe wound had increased heat and swelling and appeared to have greater tissue involvement and "? cellulitis" (acute infection of the skin and underlying tissue). His toe nail was dead and falling off and the circulation pattern on the side of his foot and base of his toes had not improved with the GTN patch. The nurse faxed her concerns to another doctor in the same practice as Dr D and requested advice.

The doctor assessed Mr A and recorded that the terminal phalanx of the middle toe of his right foot was infected and it had a very loose nail. The doctor removed the nail and recorded that the wound was dry and that Mr A's foot was pale and cool. The doctor could not feel Mr A's ankle and foot pulses or detect any peripheral pulses. Mr A's blood pressure was 156/70 (right arm lying down) and his pulse was 84 and regular.

The doctor diagnosed Mr A with peripheral vascular insufficiency, which had caused a delay in healing. The doctor requested that staff ensure that Mr A had satisfactory blood glucose control (fasting glucose 6-7 and before evening tea less than 8-9) and prescribed Fucidin Gel (antibacterial medication) to be applied twice daily to his toe.

Staff recorded that Mr A's next-of-kin had not yet been informed of the doctor's assessment. They noted that Mr A had a "? small blood blister" at the base of the great toe nail on his left foot and requested that this be assessed in the morning.

5 April
Mr B was informed about the deterioration of his father's feet. Dr D prescribed Panadol 500mg as required up to four times daily for pain relief. Mr A was administered two tablets of Panadol at 8.00pm.

6 April
Mr A was administered two tablets of Panadol at 12.00 noon and one tablet at 8.20pm.

7 April
Mr A was administered two tablets of Panadol at 12.10pm and one tablet at 8.20pm.

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8 April
Mr A's toe was redressed in the morning because he had been incontinent of urine during the night and had wet the dressing.

Dr D assessed Mr A and recorded that his toe had not improved. He ordered blood tests and prescribed Paradex, two tablets three times a day for pain relief.

Dr D also referred Mr A to Dr F, general, breast and vascular surgeon, for a review of his treatment plan. In his referral letter dated 8 April Dr D stated that Mr A had an "ischaemic/gangrenous" middle toe on his right foot with no obvious trauma (a diagram indicated that the toe had a black tip with cellulitis to the proximal phalange). The infection had been gradual. Dr D also stated that Mr A's blood sugar levels were good and that he had poor pulses. He was in moderate pain, although this was difficult to assess owing to his dementia.

Mr A was administered two tablets of Panadol at lunchtime and one tablet at 7.50pm for his sore toe.

9 April
Mr B was informed of Dr D's assessment and his father's referral to Dr F. Staff recorded that Mr A's toe remained the same and he complained of pain.

The laboratory reported that the following results requested by Dr D were outside the reference range: serum glucose level 11.6 millimoles per litre (reference range 4.0-9.5), glycosylated haemoglobin – HbA_{1c} 7.2% (reference range 4.4%-6.4%), haemoglobin 128 (reference range 132-175) and red blood cells 4.41 (reference range 4.50-6.50).

11 April
Staff recorded that the skin underneath Mr A's toe had become very white and was lifting off, and that his foot was very sore when it was dressed.

13 April
The weekly summary stated that Mr A was quite mobile despite his sore toe.

14 April
Mr A's third toe was noted to be black and necrotic and the skin on the back had peeled off. Staff recorded that the toe had "deteriorated a lot".

15 April
Dr D assessed Mr A and recorded that the infection in his toe had not spread and took a swab from the wound. The laboratory reported a moderate growth of *Staphylococcus aureus.*

16 April
Mr A was found lying on his bedroom floor. He appeared to have no injuries and was assisted back to bed. Mr A's blood sugar level was 4.4.

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18 April
Dr F assessed Mr A and wrote to Dr D. Dr F noted that over the past few months Mr A had developed a gangrenous change in the middle toe of his right foot extending back to the interphalangeal joint. The nurse from the retirement village who accompanied Mr A advised that he had quite severe rest pain and of late seemed restless and did not sleep. She also advised Dr F that Mr A was not able to reliably express this.

Dr F informed Dr D that Mr A appeared to be in quite severe pain. Dr F also noted that Mr A's forefoot was generally ischaemic as it was red and mottled and there were moderate tropic changes bilaterally. The foot pulses were not palpable although Mr A had a very good femoral pulse. A Doppler ultrasound did not detect any signal around his ankle, either over the posterior tibial or dorsalis pedis artery.

Dr F concluded that Mr A had severe occlusive disease, which had resulted in critical ischaemia of his right foot. Dr F considered that a simple amputation of the toe would fail and that in view of Mr A's age, diabetes and other comorbidities, arteriography (X-ray examination) and revascularisation would not be appropriate. The only option was amputation below the knee, which he would discuss with Mr B.

Staff recorded that Dr F suggested that they continue applying dry dressings to Mr A's wound and administer Paradex and Panadol for his pain.

19 April
Mr B was contacted about Dr F's request to attend Mr A's next appointment. Staff also recorded that Mr A passed urine on the dining room floor and a chair.

20 April
Mr A was administered two tablets of Panadol at 5.05pm for pain in his foot.

21 April
At 8.10am Mr A had an "episode" in the dining room and became non-responsive with a weak pulse. He was placed on the floor and an airway obtained. Mr A began communicating and was given two litres of oxygen through a mask. His blood pressure was 140/70, pulse 72 and regular, respiratory rate 14 breaths per minute, and he had good colour. He was transferred to bed at 8.20am and his blood pressure was recorded as 120/72, pulse 82, regular and strong, and his blood sugar level was 5.1. Mrs B was informed of the incident.

At dinner Mr A complained of pain in his foot and appeared more confused than usual. He was administered two tablets of Panadol at 5.15pm.

22 April
Dr D assessed Mr A and recorded that he had experienced a transient ischaemic attack (a "TIA") during the weekend and that his toe pain appeared controlled.

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Staff recorded in the hospital care plan that Mr A's family had requested that if he suddenly deteriorated no active resuscitation was to be commenced but only comfort measures. Staff also recorded that Dr D did not want to treat Mr A's toe with antibiotics at the moment but requested them to monitor the pain that he had reported in his left hip area. Dr D also instructed staff to administer Panadol between doses of Paradex during the day and if Mr A complained of pain at night.

23 April
Staff recorded that the GTN patch was no longer to be applied and that Mr A's wound should be dressed once daily, or if his wound became too moist, twice daily.

Mrs A advised nursing staff that Dr F would write and provide details of the consultation scheduled for 24 April.

24 April
Mr A's foot was noted to be swollen and red. His toe was quite moist and in the evening he complained of pain in his foot. Staff checked his dressing and noted that the swelling had reduced and he was encouraged to elevate his foot.

Dr F met with Mr and Mrs B and outlined the treatment options for Mr A's toe. In a letter to Dr D, Dr F stated that they decided to adopt a conservative approach, which was "managing his pain" rather than amputation.

25 April
It was recorded in Mr A's nursing care plan that he was losing the feeling in his right foot and that he had a breakdown in the circulation of his right foot, which had created a necrotic area. Staff were advised that the family had elected not to treat this condition and were requested to observe Mr A for increased pain.

Staff also recorded that the dressing on Mr A's foot had to be changed at bedtime because it was very wet. Mr A also complained of pain in his foot.

26 April
Mr A's foot was redressed twice in the morning because he was incontinent of urine three times. Staff also recorded that his urine dipstick was negative and that an "incontinence product" was to be "trialled".

Mr A was administered one tablet of Panadol at 5.00pm.

27 April
Mr A continued to urinate on the carpet in his room during the day and required toileting every two hours, but his nappy was working well at night.

Mr A was administered two tablets of Panadol at 5.15pm.

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28 April
Mr A complained of pain in his foot and was administered two tablets of Panadol at 10.30am.

29 April
Mr A was administered two tablets of Panadol at 5.00pm.

30 April
Mr A's bandage was redressed as it was very wet. In the evening he complained of pain in his foot, and was administered two tablets of Panadol at 5.05pm.

1 May
Mr A was administered two tablets of Panadol at 5.05pm and 9.45pm.

2 May
Mr A was administered two tablets of Panadol at lunchtime and 5.05pm.

3 May
In the evening Mr A's dressing was changed because it was very wet. He also complained of pain in his right foot and staff were requested to continue using Panadol between doses of Paradex (as previously instructed by Dr D).

Mr A was administered two tablets of Panadol at 11.00am and one tablet at 5.05pm for pain in his foot.

4 May
Mr A was administered two tablets of Panadol at 10.30am and one tablet at 5.00pm for pain in his foot.

5 May
Mr A's foot was noted to be sore when dressed. Staff also noticed a black mottled area slightly above the second and third toes of Mr A's left foot. He was administered two tablets of Panadol at breakfast, two at 10.45am and one tablet at 5.10pm.

6 May
Dr D assessed Mr A and recorded that toes 3, 4, and 5 were black and still very sore. Dr D prescribed DHC for pain relief, one tablet twice a day, and Lactulose 20 mg at night as required (for constipation).

Staff recorded that Mr A's mobility had decreased slightly owing to the gangrene on his right foot, and he had two small skin tears on his left foot (this was also recorded in an incident report form).

Mr A was administered two tablets of Panadol at 2.00am, 10.40am and 5.10pm. He was also administered DHC at bedtime.

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7 May
Mr A got out of bed twice during the night and stripped his bed. He was also incontinent of urine. He required two staff to assist him to walk owing to the pain in his foot. In the evening he was extremely confused and unsteady. Staff were requested to report any hallucinations and increasing confusion, as Dr D wished to consider whether these were caused by Mr A's analgesia or the "possible effects of non-treatment of gangrene process", such as septicaemia.

A special incident report form recorded that Mr A was found lying on his bedroom floor complaining that he had hit his head. He was assessed by a registered nurse, who recorded that Mr A was very confused but had equal pupil reaction. No injuries were noted. The registered nurse requested that staff monitor Mr A for a possible head injury.

The nurse manager also assessed Mr A and instructed staff to withhold the DHC, as he was not mobilising and complained that he had lost his balance. Staff recorded that this instruction was verbally confirmed by Dr D pending a review of Mr A's medication the next day.

8 May
Dr D rang to discuss Mr A's medication with staff. He prescribed MST Continus (MST) for pain relief, 10mg twice a day. Dr D discontinued the DHC and Paradex. Staff recorded that they were to use Panadol as required and report the effects of the MST.

A diagram indicated that Mr A's left foot had skin tears and a blackened area under his second toe, his right foot had blackened areas around three of his toes.

Mr A was administered two tablets of Panadol at 2.30am and 5.20pm.

9 May
Mr A was administered two tablets of Panadol at 7.30am.

10 May
Staff recorded that Mr A seemed very tired and sleepy in the morning and the MST appeared to be effective in treating the pain in his foot. In the evening he became restless and was observed hitting another patient with a shoe. Mr B and the manager of the retirement village discussed Mr A's health status and issues concerning his foot pain and amputation.

11 May
An incident report form recorded that during a routine check Mr A was found sitting on his bedroom floor. He was assessed by a registered nurse and assisted back to bed. No injuries were evident.

13 May
The weekly summary stated that Mr A was very confused and sleepy. He also kept taking the dressing off his toes and was difficult to mobilise.

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Dr D assessed Mr A and recorded that his pain relief was good with MST and "to update relatives re condition" concerning his gangrene which was advancing.

Staff recorded that Dr D observed all the wounds on Mr A's feet and considered that they had deteriorated markedly.

Mr A was administered two tablets of Panadol at 8.40am and 12.45pm.

14 May
Staff recorded that Mr A was not mobilising much as he appeared to be in pain when walking. It was also noted that small areas on the toes of his left foot appeared to be breaking down and his right foot was deteriorating.

Mr A was administered one tablet of Panadol at 8.55am and two tablets at 12.15pm.

15 May
Staff recorded that Mr A appeared to be in pain while walking and that small areas on the toes of his left foot appeared to be breaking down. His right foot was also noted to be deteriorating. At 10.00pm staff recorded that Mr A was extremely confused and disorientated.

An incident report recorded that Mr A was found sitting on his bedroom floor and appeared confused but he became quite settled when returned to his bed. He was assessed by a nurse, who recorded that he had sustained a skin tear on his left elbow, which was dressed. He had full range of movement in his left shoulder and elbow and was weight bearing. His blood sugar level was recorded as 8.9.

Mr A was administered two tablets of Panadol at 8.35am and 12.10pm.

16 May
Mr A was administered two tablets of Panadol at 8.45am, 12.10pm and 10.00pm.

17 May
An incident report recorded that during a routine check Mr A was found sitting on his bedroom floor. He had stripped his bed and pulled the drawers out of his dressing table. He was assessed by a registered nurse, who recorded that he had no injuries. In the follow-up section of the incident report form it was recorded after his discharge on 27 May that Mr A had become unable to walk unaided owing to the deterioration of his feet caused by gangrene, which became very painful despite pain relief.

Mr A was administered two tablets of Panadol at 12.15pm and 5.00pm.

18 May
Mr A was very unsettled overnight and twice stripped his bedcovers. That evening he slipped off an armchair and toppled backwards off a chair. Staff considered that these incidents occurred because Mr A was finding it difficult to walk owing to his pain, and the pain relief was affecting his co-ordination.

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It was recorded on the wound management chart that an area on the side of Mr A's right foot was oozing and black.

An incident report recorded that at 4.20pm staff found Mr A sitting on the floor beside the nurses' station after falling from an armchair. He was assessed by a care assistant, who recorded that he had no injuries. A second incident report recorded that at 6.30pm staff heard a crash and found Mr A on the floor of the indoor courtyard after falling from a chair. He was assessed by a care assistant, who recorded that a slight graze was evident on the top of his head. Mr A was assisted to his feet and placed in another chair.

Mr A was administered two tablets of Panadol at 12.20pm and 5.00pm for pain in his feet.

19 May
Staff contacted Mr B to inform him about his father's falls and let him know that Dr D would contact the family the next day. In the evening Mr A was very unsteady on his feet and became aggressive while staff were helping him to change his clothes.

Mr A was administered two tablets of Panadol at 12.20pm.

20 May
Mr A's nursing care plan recorded that he was at risk from falling owing to his increasing confusion and "? pain".

Dr D assessed Mr A and referred him to the public hospital for advice on the management of his feet. In his referral letter Dr D stated that Mr A had gangrene on his right foot, which had advanced "+++" recently, his foot was inflamed and he had no peripheral pulses. Mr A was also distressed by his pain and had increasing confusion and aggression. Dr D stated that Mr A's condition was not treatable with antibiotics, and that he had advancing pulmonary vascular disease and was an ex-smoker. Dr D prescribed morphine elixir 1mg/1ml in 5mls as required every six hours.

Staff recorded that Dr D telephoned Mr A's family about his assessment. Mr B was also advised that his father had been transferred to the public hospital.

At the public hospital a surgical registrar assessed Mr A and recorded that he had necrotic toes on his left foot, cellulitis, which had spread to his mid calf, and no popliteal pulses. The registrar's impression was that he had PVD with gangrene and cellulitis, and admitted him.

The ward nursing staff recorded that Mr A had a small (1cm) ulcerated area on his left foot. The pad of this foot was blackened with small necrotic areas on the third and fourth toes. The third and fourth toes on his right foot were completely blackened with necrosis spreading to his fifth toe. The nursing staff also recorded that Mr A had a necrotic ulcer (3-4cm) on the outer aspect of his right foot and a small broken area on his right shin, which was slightly red but had no ooze. Mr A also had a red area on his left elbow.

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22 May
A social worker met with Mrs B and discussed Mr A's need for hospital care after discharge. However, the hospice was urgently requested to admit Mr A until his family could find an appropriate hospital.

23 May
Mr A was discharged from the public hospital and transferred to the hospice. The discharge summary letter from the hospital stated that Mr A's cellulitis was successfully treated with antibiotics (flucloxacillin 1g four times a day). However, the summary also stated that after discussing the matter with Mr A's family, it was decided that conservative management was more appropriate than amputation and therefore Mr A's transfer to the hospice was for further care.

Mr A was nursed by nursing staff at the hospice primarily in bed and in a lazy boy chair and his pain managed with regular paracetamol. His foot was dressed with adaptic and charcoal daily and the medical staff noted that no antibiotics were required for gangrene.

24 May
Mr A was commenced on Nilstat (antifungal) because of a "constant red/dry mouth".

30 May
Mr A was discharged from the hospice and transferred to the private hospital in another city (where Mr and Mrs B lived). The nursing admission form stated that his skin was in good condition apart from his feet, and the nursing care plan stated that he required full assistance with cleansing and dressing.

5 June
The private hospital staff recorded that Mr A's general condition was deteriorating and he had a chest infection.

7 June
Staff recorded that Mr A's deterioration continued and his breathing was very laboured. He died at 11.25 pm.

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