Edmund Hillary Retirement Village Limited

Registered Nurse, Ms D

Registered Nurse, Ms E

Medical Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 11HDC00471)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. In 2007, Mrs A, aged 84 years, was admitted to Edmund Hillary Retirement Village (EHRV) from another residential healthcare facility. Her medical history included: Parkinson's disease, dementia, osteoporosis, recurrent urinary tract infections, postural hypotension, type II diabetes, incontinence and poor vision. Mrs A did not speak English.

2. On 18 Month4 2010, a pressure area was first noted on Mrs A's sacral area. This was managed with bed rest, use of an air mattress, regular dressing changes and two-hourly turns. The registered nurses (RNs) responsible for Mrs A's care monitored and treated the sacral ulcer. However, the sacral ulcer progressively deteriorated. During this time, Mrs A's weight was decreasing and she was assessed as requiring referral to a GP or dietitian for input into her nutrition.

3. EHRV Hospital Manager RN D was aware of the sacral ulcer but did not assess Mrs A or evaluate her condition between Month7 and Month10. EHRV Clinical Manager RN E was also aware of the sacral ulcer but did not review Mrs A or her care plan or her clinical notes.

4. On 10 Month10 Mrs A was seen by GP Dr C for a routine three-monthly review. He noted that she had a very deep necrotic 3cm diameter sacral pressure ulcer which had slowly increased over the last five months. Swabs were taken for laboratory analysis, but no other changes to the treatment plan were made. Dr C did not review Mrs A on 17 Month10 as planned.

5. On 18 Month10, RN D made a request for an urgent referral of Mrs A to the public hospital for surgical treatment of her sacral ulcer, given the worsening condition of the ulcer. She discussed Mrs A's condition with Dr C and Mrs A's family. On 19 Month10, Dr C spoke to the surgical registrar at the public hospital, who advised that Mrs A could not be admitted until 21 Month10.

6. Mrs A was transferred to the public hospital on 21 Month10. However, given Mrs A's age and medical condition, a decision was made that it was not appropriate to treat her surgically, and that palliative care was the preferred option. Mrs A died a short time later.

Decision summary

7. EHRV was responsible for providing Mrs A with services of an appropriate standard. Several RNs were responsible for caring for Mrs A and for the assessment, monitoring and evaluation of her nutritional status and sacral pressure ulcer on a continuous basis. The ulcer was clearly deteriorating from Month7 to Month10, yet none of the RNs properly assessed or evaluated Mrs A's sacral ulcer or the effect that her nutritional status was having on the healing of the ulcer, and nor did they seek specialist advice. There was a lack of communication between the RNs and RN D and RN E about Mrs A's ulcer. Staff did not communicate effectively with Mrs A or her

family about the status of her sacral ulcer. EHRV did not take sufficient steps to ensure that Mrs A was provided with appropriate care and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights[1] (the Code).

8. RN D had a personal responsibility to ensure that the care provided to Mrs A was of an appropriate standard. She failed to review Mrs A's nutritional status and sacral pressure ulcer for at least three months, from Month7 to Month10, and failed to evaluate the Wound Assessment Plan and Evaluation Form to determine whether there was any change or deterioration in the ulcer, or consider whether Mrs A's nutritional status was affecting the healing of the ulcer. RN D failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

9. RN E also had a responsibility to ensure that the care provided to Mrs A was of an appropriate standard. She failed to review Mrs A's sacral ulcer or the clinical notes, including Mrs A's care plan, at any time and failed to evaluate the Wound Assessment Plan and Evaluation Form to determine whether there was any change or deterioration in the ulcer. RN E failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

10. The Commissioner made additional comments about the care provided by Dr C.

Complaint and investigation

11. The Commissioner received a complaint from Mr B about the services that EHRV provided to his grandmother, Mrs A. The Commissioner identified the following issues for investigation:

> *Whether Edmund Hillary Retirement Village Limited provided Mrs A with an appropriate standard of care between Month1 and Month10 (2010/2011).*
>
> *Whether Dr C provided Mrs A with an appropriate standard of care between Month1 and Month10 (2010/2011).*

12. The investigation was extended to include:

> *Whether registered nurse RN D provided Mrs A with an appropriate standard of care between Month1 and Month10 (2010/2011).*
>
> *Whether registered nurse RN E provided Mrs A with an appropriate standard of care between Month4 and Month10 (2010/2011).*

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

13. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

14. The parties directly involved in the investigation were:

Mr B	Complainant/Mrs A's grandson
Dr C	Provider/Medical practitioner
RN D	Provider/Registered nurse
RN E	Provider/Registered nurse
Edmund Hillary Retirement Village Limited	Provider

15. Information was reviewed from:

Mr B
Dr C
RN D
RN E
Edmund Hillary Retirement Village Limited

Also mentioned in this report:

Mrs F	Mrs A's daughter
Mrs G	Mrs A's daughter
Mrs H	Mrs A's daughter
Ms I	Operations manager
Ms J	Wound specialist
Mr K	Village manager
Ms L	Regional manager
Mr M	Managing director

16. Independent expert advice was obtained from Ms Margaret O'Connor, a registered nurse with expertise in aged care. Clinical advice was also provided by general practitioner Dr Dave Maplesden. Ms O'Connor's report is **attached** as Appendix A, and Dr Maplesden's report is **attached** as Appendix B.

Information gathered during investigation

Background

17. Mrs A was admitted to the hospital part of EHRV in 2007 from another facility. Mrs A's medical history included dementia, Parkinson's disease, Type II diabetes, osteoporosis and recurrent urinary tract infections.

18. Mrs A did not speak English but her daughter, Mrs F, visited most days and provided care staff with a list of words in her own language to assist them to communicate with her mother. Mrs F's sister, Mrs G, visited their mother every Saturday between 9.30am and 3pm, and occasionally in the evening, and their other sister, Mrs H, visited every Sunday.

19. Mr B advised that his mother, Mrs F, is responsible for Mrs A's affairs. GP Dr C, who is contracted to provide medical services to EHRV, assessed Mrs A when she was admitted. He advised HDC that she was difficult to assess because of her lack of English and level of dementia. Mrs A's family disagreed with Dr C's diagnosis of dementia. They stated that Mrs A had a clear memory of individual family members' names, birthdays and past events. They believe that Dr C erroneously made the dementia diagnosis, because of the language barrier.

20. Dr C's plan was to continue with Mrs A's regular medications, obtain and review the nursing and medical notes from her previous residential healthcare facility, and organise baseline laboratory tests. Dr C arranged to see Mrs A monthly.

21. A comprehensive nursing care plan that identified Mrs A's health issues and care needs was developed. This was to be updated six-monthly or as required if Mrs A's health and care needs changed.

EHRV — staffing

22. The company which owns EHRV (the Company) advised HDC that the Hospital Manager has direct supervision of all staff and residents in the hospital part of EHRV. The Company advised that the Deputy/Clinical Manager has the ultimate responsibility for the delivery of services to all residents within EHRV.

23. Registered Nurse (RN) E had been EHRV's Rest Home Manager for about a year. In Month4 she was appointed as the Clinical Manager.[2] RN E resigned in Month5. As EHRV's Clinical Manager, RN E was responsible for the general oversight of the 42-bed hospital, the 52-bed rest home, 43 units of mixed rest home and hospital beds, and 60 serviced apartments. Additionally, she was involved in EHRV's preparations for the opening of a new 20-bed dementia unit. RN E was also responsible for planning and, at times, delivering staff inservice training, recruitment and staff rosters, internal audits and data collection, review of accident and incident reports, and acting as the Deputy Village Manager. Her job description outlines the duties and responsibilities of the "Deputy/Clinical Manager".[3]

24. The Clinical Manager's job description stated that the primary objective of the role was to "provide quality resident care through the effective implementation of the nursing process and to function as an effective member of the multi-disciplinary team within the guidelines and standards of current, professional nursing practice". RN E's responsibilities were to supervise and deliver nursing care, including the ongoing assessment of each resident's care needs and goals, to implement and review each resident's written care plan at regular and appropriate intervals, and to provide supervision, assistance and direction to carers to implement each resident's care plan. Another responsibility was to act as an advocate for each resident.

[2] The previous Clinical Manager resigned several months before RN E's appointment.
[3] The role was commonly referred to as "Clinical Manager", and therefore that term has been adopted throughout this report.

25. Between Month1 and Month10, RN D was EHRV's Hospital Manager. The Hospital Manager job description stated that one of the key responsibilities for this position is the delivery of nursing care according to the Nursing Process — "ensuring all care is assessed, planned, implemented and evaluated to meet the needs of individual residents". The Hospital Manager was also responsible for providing support, guidance, assistance and direction for all RNs and Care Assistants to implement the residents' nursing care plan, acting as advocate for each resident, liaising with residents' families, co-ordinating doctor's visits on a three-monthly basis, and keeping the doctors informed of each resident's condition and of any deterioration or changes as they occurred.

26. The Hospital Manager and the Clinical Manager met daily when both were on shift for a verbal "catch-up" and, over the course of a day, the Deputy/Clinical Manager "undertook frequent visits to meet and liaise with staff on all floors".

27. The RN job description outlines the responsibilities of RNs, which include supervision and delivery of nursing care, on-going assessment of each resident's care needs and goals, and implementation and review of the resident's care plan, ensuring accurate and precise documentation, acting as advocates for each resident, and ensuring that residents are examined not less than once a month by the GP and as clinically indicated unless the resident is assessed by the GP as stable.

EHRV policies

28. The Company provided HDC with various policies. Relevant to this complaint is the "Principles of Wound Management" document. The document states that a resident's wound is to be individually assessed, monitored and evaluated by an RN on a continuous basis, and appropriate specialist advice is to be sought as assessed necessary by an RN, from a GP, specialist doctor or wound specialist nurse. The document describes the assessments and evaluations required to choose the wound care product and regimen to promote optimal healing. It also details the process of wound healing, a dressing selection chart, and wound care practice guidelines.

29. The Company's Operations Manager, Ms I, advised HDC that the following processes were in place at EHRV to ensure that the Hospital Manager and/or the Clinical Manager were alerted to care staff concerns about a resident's status:

1. Documentation Nursing Assessment, Care Planning and Progress Notes General. This policy documents the process from completion of initial and ongoing clinical paperwork, including short- and long-term care planning and progress reporting.

2. Duty Handover Report. The policy specifies the times of handover and information about residents that is to be discussed, such as changes in health status and any events requiring specific attention.

3. Communication of Resident Wellbeing. This policy requires regular and as required clinical care meetings between the Hospital Manager and the RN/EN and care staff. These usually took place once a month.

30. Ms I advised that the Hospital Manager met with the RNs/ENs on a daily basis to receive a handover of any changes to the residents' health status or other appropriate information. However, the regular meetings between the Hospital Manager and care staff stopped in Month3, but recommenced in Month8, led by the Deputy/Clinical Manager.

31. Ms I stated that it was expected that the Hospital Manager would periodically review all documentation within a resident's file, particularly when the resident's condition was deteriorating, to ensure that staff were directed in his or her care and to offer support and guidance as required.

Mrs A

32. On 21 Month1, it is recorded in the nursing progress notes that Mrs A had developed a pressure ulcer on her right earlobe. Dr C was advised and he examined Mrs A. He ordered a swab to be taken for laboratory analysis, Foban antibiotic cream to be applied, and the area to be dressed. When the laboratory test result was communicated to Dr C on 1 Month2, he discontinued the Foban cream and started Mrs A on the oral antibiotic flucloxacillin. By 9 Month2, the pressure ulcer on Mrs A's ear had healed.

33. On 19 Month2, Mrs A was weighed and noted to have lost 1.3kg over the previous month. It is recorded in the Progress Notes that Mrs A continued to have a poor appetite but would drink fluids with encouragement.

34. On 14 Month3, a caregiver reported to the RN on duty that Mrs A had a pressure ulcer on her left heel. A Hydrocolloid dressing[4] was applied. The RN recorded in the Progress Notes that staff were to monitor the ulcer, and place Mrs A's feet in Spenco booties to avoid further pressure areas developing.

35. On 27 Month3, it was recorded in the progress notes that Mrs A's pressure ulcer on her left heel was redressed according to the wound care plan.[5] The Care Assistant reported that she had noted that Mrs A had a small pressure wound on her sacrum. The area was cleaned and dried, and a Hydrogel dressing[6] was applied. Mrs A's daughter, Mrs F, was advised about her mother's pressure areas.

36. Mrs F "strongly disputes" that she was ever told that her mother had a sacral wound.

37. On 4 Month4, Mrs F was concerned about a pressure sore that had developed on one of her mother's ears.

38. On 7 Month4, Dr C reviewed Mrs A after concerns were raised by Mrs F. Dr C ordered a series of blood tests for Mrs A, but gave no further orders to care staff.

[4] The moist conditions produced under the Hydrocolloid dressing are intended to promote wound healing, without causing softening and breaking down of tissue.
[5] EHRV did not provide a Wound Assessment Plan and Evaluation Form for Mrs A for the management of the ulcer to her left heel.
[6] Hydrogel dressing is designed to hold moisture in the surface of the wound, providing the ideal environment for both cleaning the wound, and allowing the body to rid itself of necrotic tissue.

39. When Dr C reviewed Mrs A on 14 Month4 for her routine three-monthly check, he noted that he had discussed with Mrs F, Mrs A's "recent ischaemic chest pain episode" and that, "Daughter agrees [with] 'Do Not Resuscitate'".

40. In Month4 Mrs A's weight was recorded as 45.5kg. A Nutritional Assessment Form[7] was completed in Month4. Mrs A scored 5 points out of a possible 14. The Nutrition Assessment Form noted that a patient with a score of 11 was at risk of malnutrition and should be started on nutritional supplements, and a patient with a score of 11 or less, was to be referred to the GP or a dietitian. The form was annotated on 13 Month4 recording that Mrs A was to be given a nutritional supplement, Diasip, twice daily. There is no record that this low assessment score was brought to the attention of Dr C or that a referral to a dietitian was considered.

41. The Long Term Nursing Care Plan updated on 16 Month5 instructed staff regarding Mrs A's dietary management, which included monitoring her for signs of dehydration and weighing her each month. Any decrease/increase in weight was to be reported to the RN. The progress notes from this time show that Mrs A was provided with the nutritional supplements Fortsip, Diasip and Complan.

Sacral wound management

42. On 18 Month4, it was recorded in the Progress Notes that the pressure area on Mrs A's sacrum was "starting to build up".

43. On 8 Month5, an RN completed a Wound Assessment Plan and Evaluation Form for the management of Mrs A's sacral pressure sore, which was described as a reddened area measuring 4cm x 2cm. Staff were instructed to dress the area with Hydrocolloid and to turn Mrs A two hourly when she was in bed.

44. On 10 Month5, Mrs A's risk for developing pressure ulcers was assessed using the Waterlow score. Mrs A's score was established as 28.[8]

45. The Long Term Nursing Care Plan, updated on 16 Month5, noted that Mrs A was at high risk for pressure areas. The plan instructed staff to change her position every two hours when she was in bed, and noted that she was to be nursed on a pressure-relieving mattress. Mrs A's skin integrity was to be checked each morning and changes reported to the RN.

46. Mrs F stated that she visited her mother frequently during the time she was at EHRV, often staying for many hours, and at no time did she witness her mother being turned two hourly. Mrs F said that she witnessed an occasion when a staff member signed off the continence checksheet, when she had not checked the status of Mrs A's

[7] The Nutrition Assessment form scores the patient for risk for malnutrition, assessing food intake, weight loss in the previous three months, mobility, neuropsychological problems and clinical impression, to a maximum score of 14.

[8] The Waterlow score is used to determine the level of risk of a given patient for developing pressure ulcers. Potential scores range from 1 to 64. A total Waterlow score ≥10 indicates risk for pressure ulcers. A high risk score is ≥15. A very high risk exists at scores ≥20.

continence. Mrs F's sisters, Mrs G and Mrs H, support Mrs F's recollection that the two-hourly turns were not always carried out.

47. RN E stated that she was not advised about Mrs A's sacral wound until mid-Month5. She was advised at that time that the wound had started to improve. RN E stated:

> "As a result of this total lack of communication, I was unable to have any input into [Mrs A's] wound care. If I had been informed of the facts, I would have personally inspected the wound and sought expert advice from Nurse Specialist, [Ms J]. … After [mid-Month5] I did not have any discussions with the RNs or Hospital Manager about [Mrs A's] wound issues because the deterioration was never reported to me or raised in any clinical meetings or elsewhere."

48. RN D said that during Month4 she and RN E were "under tremendous pressure". She said that they were working long hours and mentoring staff in order to raise the standard of resident files and documentation, because EHRV was working towards an audit. RN D stated:

> "My practice was to do a round of the hospital residents in the morning around 7.15am, and then before I left in the afternoon. … Whenever I saw [Mrs A], as she could not converse in English, I would greet her in her own language. I would check that her air mattress was at the correct setting, that the mattress was in fact inflating the cells as it should, plus checking on the positioning of her head.
>
> The registered nurses informed each other at afternoon handover one day in [Month5] that [Mrs A] had developed a pressure sore. We discussed what strategies should be implemented, such as two hourly turns and keeping her off her back. Turning forms were drawn up and the Care Givers were instructed to turn her.
>
> Every morning and afternoon, I checked the turning charts to see that [Mrs A] was being turned. I did observe Care Givers going into [Mrs A's] room to turn her and I watched them do it on a number of occasions. I can recall sighting the first wound in late [Month6], early [Month7] and the wound area had decreased in size.
>
> One of the RNs who started working in the area during [Month5] (as I recall the date) was a wound specialist. … [T]he other RNs would ask his advice on how to treat [Mrs A's] wound at handover. I was privilege [sic] to these discussions a number of times, and at no time during the subsequent handovers did the RNs raise any serious concerns about the wound. … Seeing we had … a wound care specialist on our staff, I accepted his input into the care of [Mrs A's] wound believing that he was providing sound advice. I wish now that I had had more personal involvement with [Mrs A] at this time."

49. On 18 Month5, it was recorded in the progress notes that the pressure wound on Mrs A's sacrum was healing and the redness to her mid-spinal area was improving. On 20 Month5, it was recorded in the Progress Notes that Mrs F visited Mrs A and "understood the rationale of not placing [Mrs A] on lazyboy". There is no reference to

any staff specifically telling Mrs F about, or showing her, the sacral ulcer. However, the following day, the duty RN recorded that she talked to Mrs F about the deterioration in her mother's health. The RN noted: "Unsure if [Ms F] is aware or understood as she verbalises how well her mother eats and remembers the past."

50. Throughout Month5, the care staff continued to record the management of Mrs A's pressure area on the Wound Assessment Plan and Evaluation Form in accordance with the Nursing Care Plan. Staff also recorded Mrs A's poor food and fluid intake, despite daily lunch-time assistance from her daughters.

51. On 12 Month6, it was recorded in the Progress Notes that the sacral ulcer was healing "poorly". The progress note for 13 Month6 stated that Mrs A's sacral ulcer "seemed to appear worst (sic) than previous days".

52. The Wound Assessment Plan and Evaluation Form update for 12 Month6 noted that the wound was healing "poorly" and, on 16 Month6, the wound was noted to have increased in size since 11 Month6. On 17 Month6 the wound dressing was changed from Hydrocolloid to Algsite (for moist wound management) and Permafoam[9] dressings, secured with Omnifix.

53. On 22 Month6, Mrs A's sacral wound was noted to be improving, and the dressing protocol was changed back to Hydrocolloid.

54. On 30 Month6, it was noted that Mrs F told the duty RN that her mother wanted to know why she was always in bed. The RN asked Mrs F to explain to Mrs A that she was being kept in bed, instead of her chair, in order for her sacral ulcer to heal completely. The RN recorded that this explanation was accepted.

55. On 10 Month7, Mrs A's sacral ulcer was found to have increased in size, and a new plan of dressing with the low-adherent surgical dressings Cuticerin and Interpose, and then Opsite to cover, was written up.

56. Dr C undertook his three-monthly review of Mrs A on 16 Month7 noting that her weight was "now" 44 kg,[10] her diabetes was well controlled, and her vital signs[11] were stable. There is no mention of the sacral ulcer.

57. Mrs A's weight chart showed a steady decline in her weight, from 45.5kg in Month4 to 42.5kg in Month7. The weight chart was annotated with comments relating to Mrs A's weight loss, and her poor appetite, but there was no change in management.

58. On 18 Month7, it was noted on the Wound Assessment Plan and Evaluation Form that Mrs A's sacral dressing was "soaked with brownish ooze". There was no change to management of the wound noted, or any record of this in the Progress Notes, or that

[9] A foam wound dressing with properties that make it particularly appropriate for the treatment of chronic ulcerated wounds with aggressive exudate.
[10] Mrs A's weight chart shows that her weight in Month6 was 44.10kg.
[11] Temperature, blood pressure and pulse.

the change in the status of Mrs A's wound was reported to RN D, RN E or Mrs A's family, or that consideration was given to reporting the change to the GP.

59. Mr B stated that the family were not advised about the state of his grandmother's sacral wound at this time, or about the "brownish ooze".

Sacral wound management

60. Throughout Month8, staff continued to record the management of Mrs A's sacral ulcer. On 10 Month8, it is recorded in the Wound Assessment Plan and Evaluation Form that Mrs A's sacral ulcer was "healing slowly", but on 17 Month8 it was noted to be "worsening" with "macerated skin (surrounding the sore)", and the dressing requirement was to be reviewed. On 26 Month8, it was recorded in the Progress Notes that there was "very little improvement" to the sacral ulcer and, on 28 Month8, it was noted to be "healing poorly".

61. It was recorded in the Progress Notes for the latter part of Month8 that Mrs A's general condition appeared to have improved, her fluid intake had increased, and the recording of her fluid intake was to be discontinued.

62. On 13 Month8, Dr C was asked to review Mrs A as she had been unwell the previous day with chest pain, she was not swallowing food, and her food and fluid intake was declining. Dr C spoke to Mrs A's family about her condition, asked the nursing staff to monitor her fluid balance closely, and ordered various laboratory tests.

63. Dr C recorded: "[Mrs A appears] back to her normal self this morning", and noted that she required two-hourly turning as she had a pressure sore. It appears that Dr C did not examine Mrs A's sacrum. Dr C advised HDC that there was no indication given to him by the RNs that the pressure sore required a specific assessment or was of concern.

64. A Nutritional Assessment performed on 13 Month8 recorded Mrs A's score as 1. Mrs A's weight chart showed her Month8 weight to be 41.15kg.

65. On 16 Month8, the duty RN instructed staff to offer Mrs A "oral fluids as much as possible", and to enter her fluid intake on a Fluid Chart.

66. On 4 Month9, it was recorded in the Progress Notes that there had been an increase in the size of Mrs A's sacral ulcer, but there was no sign of infection or ooze. The management of the ulcer remained unchanged for the remainder of Month9. On 11 Month9, it was noted on the Wound Assessment Plan and Evaluation Form that the depth of the ulcer had increased, and on 18 Month9 that it was larger than three weeks previously.

67. On 7 Month10, an RN recorded on the Wound Assessment Plan and Evaluation Form:

> "Worsening since I last saw on [28 Month9]. Redress as per plan, surrounding skin macerated, odourous, moderate serous ooze. Daily check."

68. It was also recorded in the Progress Notes that Mrs A's sacral ulcer had deteriorated, and that her temperature was noted to be within normal limits at 36.4°C when it was taken at 12.30pm. There was a suggestion in the Progress Notes at 10pm that the ulcer might benefit from a honey dressing.

69. On 10 Month10, Dr C saw Mrs A for her routine three-monthly review. Mrs F was present during Dr C's visit and requested that her mother's bedtime dose of Sinemet[12] be stopped.

70. Dr C ordered a wound swab to be taken from Mrs A's sacral ulcer for laboratory testing, and recorded in his medical notes:

> "Has a very deep & necrotic 3cm diameter sacral pressure sore — started 5/12 ago & slowly increasing in size despite expert nursing care — 2hrly turns/air mattress/dressings. Patient appears to have some pain from this.
>
> Plan (1) Swab then [Dr C] R/V next wk
>
> (2) No other changes @ moment except for ↓ frequency of Sinemet as required by daughter.
>
> NB/ 4kg weight loss last 3/12!"

71. Dr C advised HDC that, as this was his first assessment of the ulcer, he considered it necessary to ascertain further information about the sore and obtain the result of the wound swab he took that day and sent to the laboratory, before making any further decisions such as antibiotic treatment. He planned to review Mrs A the following week. Dr C said that he reduced the frequency of Mrs A's Sinemet at Mrs F's request. However, it appears that he did not advise Mrs F that her mother had a serious pressure ulcer.

72. Dr C advised HDC that he did not see Mrs A the next week, on 17 Month10, as he had intended. He said that he viewed the laboratory generated swab test result and advised the RN assisting him that day that Mrs A did not require antibiotics, but he omitted to see Mrs A because her file was not on the ward-round trolley, and the RN did not remind him that he had planned to review Mrs A that day.

73. EHRV advised HDC that GP review visits are recorded in "V/Care",[13] which is a computer based system that provides an alert when a routine GP visit is due. This alert system enables staff and/or the hospital manager to inform the GP that a visit is required, prepare for the visit and invite the next of kin to attend.

74. RN D advised HDC that she was unaware of any problem with Mrs A's sacral ulcer until 18 Month10, when one of the RNs told her that the wound was particularly smelly, and asked RN D to arrange for the doctor to review Mrs A.

[12] Used to treat tremor, weakness and muscle stiffness caused by Parkinson's disease.
[13] A software package designed to manage resident care (such as care plans and assessments), and record occupancy, financial and marketing information.

75. There is no record in the Progress Notes that any of the RNs involved in Mrs A's care reported the changes to Mrs A's sacral ulcer from Month 8 to Month10 to RN D, RN E or Mrs A's family.

76. At 11.05am on 18 Month10, RN D recorded in the Progress Notes that she faxed Dr C a request for an urgent referral to the public hospital for Mrs A for debridement[14] of the sacral ulcer. RN D then recorded that she received a call from the District Health Board's (the DHB) wound specialist Ms J to advise that the earliest she could visit to review Mrs A would be 22 Month10. RN D noted that Ms J recommended that Mrs A be sent to hospital as soon as possible. At 11.15am, RN D followed up the fax with a telephone call to Dr C's surgery to advise him of her discussion with Ms J.

77. At 1.20pm, RN D spoke to Mrs F to advise her of the possibility of her mother being admitted to the public hospital.

78. At 10.15am on Saturday 19 Month10, RN D contacted Dr C at home, to advise him that Mrs A's sacral wound was worse — it was very odorous and painful. RN D recorded that Dr C would contact her after he had spoken to the surgical registrar at the public hospital.

79. At 1.10pm, Dr C telephoned EHRV to say that although the registrar agreed to admit Mrs A to the public hospital, this could not happen until Monday 21 Month10. Dr C said that he would speak to the surgical registrar again on 21 Month10, and would advise EHRV of the outcome of that discussion. Mrs A's daughters were advised of the plans with respect to admitting their mother to the public hospital. Mrs G said that the first time she became aware of the seriousness of Mrs A's sacral pressure wound was on 20 Month10, when she was present when a nurse came to change the dressing. Mrs G asked to see the wound and was shocked to see that it was large, black and odorous.

80. At 10am on 21 Month10, EHRV staff received a call from Dr C confirming that the surgical registrar had accepted Mrs A. An ambulance was booked for 11.30am to transfer Mrs A to the public hospital, and her daughters were advised.

81. There is no reference in the Progress Notes after Month6 indicating that Mrs A's family was specifically told about the continued existence of, or change to, her sacral ulcer. RN D told HDC that she believes that Mrs A's family was aware of the ulcer; however, she acknowledged that she did not document one occasion when she advised Mrs F that Mrs A should not sit in a chair because of her sacral ulcer.

82. Mrs F and Mr B stated: "We strongly dispute that [RN D] believed [the] Family was aware of the ulcer."

[14] Surgical excision of dead, devitalized, or contaminated tissue and removal of foreign matter from a wound to assist healing.

The public hospital

83. On 22 Month10, the public hospital staff met with Mrs A's family to discuss options for her care. The surgical consultant explained the extent of the ulcer and told the family that Mrs A's age, co-morbidities and quality of life issues were contraindications for her having an operation to debride the wound. He recommended that Mrs A be provided with comfort/palliative care and simple dressings to her sacral wound. A referral was sent to the Palliative Care Team for Mrs A.

84. Mrs A was transferred to another facility for ongoing care.

85. Mrs A died a short time later.

Additional information

RN D

86. RN D stated that RN E had to continue as Rest Home Manager after she had taken over as Clinical Manager, which put considerable strain on the clinical team. RN D said that she volunteered to take over the supervision of 12 rest home level residents in the Services Apartments/Assisted Living area of EHRV, to relieve RN E. RN D said that she saw these residents weekly and wrote the progress notes for them. She stated:

> "There were at least five of these residents who should have been transferred into the Rest Home for appropriate care, but because they had purchased their apartments, the [Company] hierarchy said we, the nursing staff, could care for these people adequately in their apartments. Numerous problems arose with this arrangement and there were many meetings with irate residents' families who were upset that their loved ones were not being attended to properly. …
>
> When the Rest Home Manager was off duty, which was on a Friday and Saturday, I was the only senior clinical person on duty for the entire facility of 500+ residents. So when there was a problem in the Independent Living residents, like a fall or any other emergency, I had to leave my area to attend whatever had happened. …
>
> Over the weekends it was expected that [RN E] and I had to show prospective residents and their families around the facility and [we] were expected to drop everything to do it. There were therefore frequent, serious and lengthy interruptions to the time which we had to deal with our other work."

87. RN D advised HDC that she and RN E informed the Company's Regional Manager, Ms L, and EHRV's Village Manager, Mr K, that they felt clinically unsafe. However, they did not document their concerns.

88. RN D advised HDC that she was originally offered the position of Rest Home Manager and signed that job description. However, she actually took up the position of Hospital Manager because the person in that position left before RN D commenced working at EHRV. RN D advised HDC that she was never given the job description for the Hospital Manager role but believed that "there was very little difference

between what would be in the job descriptions of Hospital Manager and Rest Home Manager". She understood that she was "primarily responsible for the clinical care provided and non-clinical management in the Hospital part of the facility".

89. RN D also advised HDC that when Mrs A's sacral ulcer reopened at the beginning of Month8, RN D was on leave and RN E was acting as Hospital Manager. RN D returned from leave on 18 Month8, and she advised HDC that a week later she heard about the "status" of Mrs A's sacral ulcer but "assumed everything was being dealt with appropriately". She accepts that after that she "lost track of things going on with [Mrs A]" and in Month9 did not focus on the need to visually assess the sacral ulcer. She also "forgot to mention the pressure sore that [Mrs A] had developed" in her meetings with RN E (which were generally weekly) and management meetings. RN D accepts that she relied on the RNs to be proactive in relation to the residents' care and to keep her updated.

RN E

90. RN E stated there was no Clinical Manager at EHRV at the time she was appointed. As part of her orientation, she was sent for a three-day visit to another of the Company's facilities to receive some guidance from the Facility Manager there. RN E said she spent a short period with the Clinical Manager there and some time with the various unit leaders.

91. RN E said that when she was appointed as Clinical Manager, the facility structure changed and the Company did not employ anyone for the Rest Home Manager position to replace her. RN E stated that the Clinical Manager role at EHRV had a "huge workload for one person" and she worked late every night as well as taking work home at the weekend. She said that she had to rely on RN D to provide direct, hands-on management, support and oversight of the 42 hospital residents in her area and report any concerns about residents and staff.

92. RN E stated:

> "It was the expectation that the RNs and ENs[15] would run their areas without a manager and report directly to me. I did bring up my concerns around the clinical safety in these areas to the Regional Manager, [Ms L], in approximately [Month6] and to the Village Manager, [Mr K]. I thought this new structure put extra strain on me as the Clinical Manager."

93. RN E told HDC that she was told in mid-Month5 that Mrs A's sacral ulcer had improved and was almost healed. RN E advised that she was never informed of the deterioration of Mrs A's ulcer despite making daily rounds to all areas of EHRV.

Dr C

94. Dr C stated:

[15] Enrolled nurses practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education to health consumers in community, residential or hospital settings.

> "I have taken the time to consider my management of [Mrs A] and with the benefit of hindsight I accept that I should have referred her for admission on [10 Month10]. However it must be borne in mind that this was the first time I had seen [Mrs A] for this concern, which had been managed by the nursing staff for some months, and I considered it necessary and prudent to obtain/gather further clinical information by seeking the necessary tests. My plan was to review her in a week's time after the results were available and for the nursing cares to continue. Much to my regret I did not review her as I planned as this was not recorded in the ward diary in accordance with standard practice. …
>
> In summary I would agree with Dr Maplesden's comment that 'failure to review the wound on [17 Month10] was probably a mild departure from expected standards', but it is my opinion that this failure was primarily the result of inadequate systems and processes around the scheduling of follow-up patient appointments at EHRV. …
>
> I am sorry for the distress that [Mrs A's] illness and care has caused her family."

EHRV response

95. Regional Manager Ms L responded to the complaint in relation to the management of Mrs A's pressure area. Ms L advised HDC that Mrs A's care was well managed for the four years she was with EHRV, but acknowledged that from Month8, more robust intervention should have been implemented and the deterioration of Mrs A's wound better evaluated. Ms L stated:

> "As part of the Hospital Manager's responsibility and as detailed in her job description there was an expectation that as [Mrs A's] wound deteriorated a visual review and evaluation of the wound should have been undertaken by her with escalation for specialist intervention, such as GP or specialist wound care. The pressure area should have been discussed by the hospital manager at weekly senior clinical meetings and therefore brought to the attention of the Clinical Manager for input. … We acknowledge there was an opportunity from [Month8] onwards for the Hospital Manager to have effectively communicated with the Clinical Manager, the GP, the Gerontology Nurse Specialist and the family regarding [Mrs A's] deteriorating health and wound status."

96. Ms L said that the RN and Hospital Manager's role would be to ensure that the wounds had been assessed by an RN on a wound assessment plan, and correctly documented and followed up with progress notes on the wound assessment plan and in the nursing progress notes. She stated that RNs are required to communicate directly with their manager to ensure optimal nursing care.

97. Ms L stated that six RNs were involved in the management of Mrs A's sacral pressure wound. Ms L said that no one RN was consistently overseeing the wound "for the timeframe in question" — Month4 to Month10 — because of annual and maternity leave. Ms L advised that the RNs concerned were involved in discussions regarding the family's complaint to EHRV, and indicated that they had made RN D aware of the

deterioration of Mrs A's wound on several occasions. Ms L said that it was the actions of two of the RNs that escalated events on 19 and 21 Month10.

98. Ms L advised that staff "genuinely believed" that Mrs A's nutritional status was adequately monitored, as the nursing notes regularly referred to her poor appetite and that she was refusing food. Mrs A was placed on a Food and Fluid Balance Chart and offered Diasip twice daily. Ms L said that Dr C was aware of Mrs A's nutritional status, and discussed her deteriorating condition, poor swallowing and reduced food and fluid intake with her family. Ms L stated:

> "To this end the GP was very aware of [Mrs A's] nutritional status and actively involved. It is not imperative (nor EHRV policy) that every resident must be reviewed by a dietitian especially when the GP is involved."

99. Ms L stated that between Month0 and Month3, EHRV employed a registered nurse as Clinical Manager. RN E became the Clinical Manager on 26 Month6. Ms L said that there is no evidence in the EHRV handover books or minutes of meetings that RN E and the previous Clinical Manager had been aware of the status of Mrs A's pressure area.

Actions taken

100. On 30 Month10, EHRV Village Manager Mr K was advised by a social worker from the public hospital that Mrs A's family did not wish her to return to EHRV. Mr K contacted Mrs F later that day and invited the family to meet EHRV staff to discuss their concerns.

101. Mr K and RN E met with Mrs F and her son, Mr B, and two of Mrs A's friends on 30 Month10. Mr K expressed regret that the family did not wish Mrs A to return to EHRV. Mrs A's family stated that they were unhappy with the care provided to their mother and grandmother, and the manner in which staff spoke to family members.

102. Mr K advised the family that Ms L had been advised of their concerns, and would be happy to meet them to discuss their concerns further. Ms L and Mr K met the family at the family home. Ms L apologised for any distress that had been caused, especially in relation to the management of the pressure ulcer and the lack of communication with the family, and assured the family that the Company was taking their concerns seriously and would commence a full investigation. The family requested a copy of Mrs A's EHRV clinical records. This documentation, and a letter of apology from Ms I, was sent to the family.

103. Ms L had ongoing contact with Mrs A's family and updated them on progress of the investigation and advised them that a Quality Improvement Plan had been implemented.

Quality Improvement Plan

104. On 16 June 2011, Ms L advised HDC that as a result of these events a Quality Improvement Plan had been implemented. Included in the plan was that the Clinical Manager was to review all the patient/resident wound charts, ensuring that Waterlow

scores are accurate, and update the wound management plans in collaboration with the DHB's Gerontology Nurse Specialist, and that this was to be completed by the end of Month11. Another strategy to improve the service was for an RN (who is a member of the New Zealand Wound Care Society and has completed several external training sessions on wound care) to take a leadership role in wound care and be the on-site point of contact for wound care. Further, EHRV was to provide additional training for staff on pressure care prevention and management. A number of pressure care training sessions were held in Month10 and Month11.

Referral to Nursing Council of New Zealand

105. Ms L advised the Nursing Council of New Zealand (NZNC) that the Company had conducted an investigation relating to RN D's competency in relation to her management of a resident with a pressure sore, which "raised concerns about RN D's ability to perform her role as Hospital Manager".

106. Ms L's notification regarding RN D was referred to NZNC's Professional Standards team for further consideration.

107. NZNC advised HDC that the Professional Standards team had decided to take no further action regarding RN D's competence.

Response to provisional opinion

The family

108. Mr B advised HDC that there were a number of occasions on which staff ignored his mother's requests for pain relief for Mrs A, and for assistance to change Mrs A's incontinence pad when Mrs F found that her mother had defaecated and the pad had not been changed. When Mrs F repeated her requests, one or two of the staff became angry and responded with a raised voice that the incontinence pads were changed only at 7pm.

109. Mrs F said that on 10 Month10, she raised her concerns about these issues with EHRV Facility Manager Mr K, who assured her that Mrs A's incontinence pads would be checked two hourly. Mrs F stated that, despite Mr K's assurances, Mrs A's pads were not changed until 7pm.

110. Mrs G and Mrs H support Mrs F's recollection that care staff did not turn their mother two hourly as directed, or change her incontinence pad sufficiently often. Mrs G stated that her mother was given raw salads, which was "hardly the type of food you would feed an elderly [person] who has lost her teeth [and] requires soft food". Mrs G said that her mother would often talk about having no food or fluid offered during the night.

RN D

111. RN D advised HDC that she did not wish to comment further on this matter. RN D provided HDC with a letter of apology for forwarding to Mrs A's family.

RN E

112. In response to the provisional opinion, RN E stated that she was very distressed by the finding that she failed to provide Mrs A with services with reasonable care and skill. RN E submitted that this was not the finding of the EHRV investigation into this case, which reached the view that there was no shortcoming on her part. RN E stated that she was unaware of the status of Mrs A's pressure area, and agreed with the Regional Manager, Ms L, who identified that RN D was remiss in not reporting Mrs A's condition to RN E, as the Clinical Manager. RN E stated that she does not consider that she can be held responsible when RN D had the opportunity to bring Mrs A's status to her attention.

113. RN E advised that it was a "practical impossibility" for her to be aware of the care provided to every patient and resident at EHRV. She stated that her workload was very demanding and:

> "I sought and obtained employment elsewhere to remove myself from the risks presented by that role. …
>
> Please be assured that, in making the comments above, I am not avoiding the critical assessment of my own performance. I am receptive to learning lessons and looking for ways to improve performance. However, I genuinely feel that, in the context of my role at EHRV, I did not fall short of professional standards in connection with the care of [Mrs A].
>
> Aged care is an incredibly demanding area of clinical practice, where morale is often low. I am a hardworking and committed practitioner."

Dr C

114. Dr C reiterated his comments that his failure to review Mrs A was primarily the result of inadequate systems and processes at EHRV around the scheduling of follow-up patient appointments. He advised that he has to rely on administration and nursing staff to advise him who requires a consultation or follow-up. Dr C advised HDC that he has "on many occasions reflected" upon the fact that he did not review Mrs A on 17 Month10. He said: "She should have been [followed up] and I regret that did not occur." Dr C stated: "As previously conveyed I am sorry for the distress that [Mrs A's] illness and care caused her family."

EHRV

115. Managing Director Mr M responded to the provisional opinion, noting that the organisation had already apologised unreservedly to Mrs A's family, verbally and in writing. However, he provided HDC with a letter for forwarding to Mrs A's family, apologising for EHRV's breach of the Code.

116. Mr M reiterated comments made by EHRV that RNs did take their concerns about Mrs A's sacral ulcer to RN D, and were appropriately supported and assisted to raise those concerns. He advised that both RN D and RN E were aware of Mrs A's sacral ulcer and had multiple opportunities to review and assess it.

117. Mr M advised HDC that the Company has amended its Wound Management Policy (the Policy) to ensure that all wounds of two months or greater duration will be reviewed by a wound specialist or GP. The Policy now identifies the staff member responsible for reviewing the information provided by the VCare reports. A wound specialist has been employed in the villages in the region owned by the Company. A copy of the Policy and VCare report was provided.

118. An audit of EHRV has been arranged for 11 and 12 Month4 2013, to be undertaken by HDANZ, as part of a HealthCERT certification audit. Mr M stated that the audit will focus on the policies developed by the Quality Improvement Plan and staff training in these policies.

119. Mr M also stated that when the DHB undertook an issues-based audit on 1, 2 and 16 June 2011, one of the issues addressed by the audit was whether the staffing levels and mix at EHRV were appropriate to the number, range and complexity of the clients. Mr M stated that the audit found that EHRV was 100% compliant with the contract it held with the DHB.

Opinion: Breach — Edmund Hillary Retirement Village

120. Mrs A was elderly and unwell and did not receive the care to which she was entitled. She developed a pressure ulcer that lasted for five months, and while this was cared for on a day-to-day basis, none of the staff properly evaluated the ulcer or sought assistance from a doctor or wound specialist when it started to deteriorate in Month7.

121. I note that my expert nursing advisor, Ms O'Connor, stated that with the exception of her nutritional status, Mrs A's health "appeared to be 'appropriately monitored and documented'". However, Ms O'Connor advised that in regard to the sacral pressure area, from Month8, "more robust intervention should have been implemented and the deterioration of the wound better evaluated with more effective communication with [Mrs A's] family".

122. In my view, in failing to adequately assess and evaluate Mrs A's sacral pressure ulcer, monitor her nutritional status, and effectively communicate with Mrs A and her family, EHRV did not provide Mrs A with services of an appropriate standard. I note that EHRV accepts that more robust intervention should have been implemented and the deterioration of Mrs A's ulcer better evaluated.

123. I have identified my concerns about the decision-making and actions of individual staff; however, in my view, EHRV had the responsibility to operate the hospital in a

manner that provided Mrs A with services of an appropriate standard. This includes responsibility for the actions of its staff.

124. Rest home owners have an organisational duty of care to provide a safe healthcare environment for their residents. This duty of care includes ensuring that staff work and communicate effectively together, ensuring that the policies and procedures are consistent with relevant standards, and ensuring that staff comply with those policies and procedures.[16] The systems within which a team operate must function effectively in order to provide an appropriate standard of care to the residents.

125. EHRV advised that several RNs were responsible for caring for Mrs A. The job description for RNs states that they are responsible for on-going assessment of each resident's care needs.

126. According to the "Principles of Wound Management" document, RNs are responsible for assessing, monitoring and evaluating a resident's wound on a continuous basis, and appropriate specialist advice is to be sought as assessed necessary by an RN, from a GP, specialist doctor or wound specialist nurse. Mrs A suffered from a sacral ulcer for almost six months and, for the last three months, the ulcer was clearly deteriorating. I am concerned that none of the RNs who cared for Mrs A properly assessed or evaluated the ulcer, and none sought specialist advice until Month10 in light of an obvious deterioration from Month8. In addition, the RNs did not raise any concerns about the ulcer with Dr C when he reviewed Mrs A in Month7 and Month8.

127. When Mrs A's nutritional assessment was completed in Month4, it was noted that she scored 5 out of a possible 14. The Nutritional Assessment Form instructed that if a patient scored below 11, the patient was to be referred to the GP or a dietitian. Although Mrs A was started on a dietary supplement at this time, Dr C was not advised about Mrs A's low assessment score, and there was no referral made to a dietitian.

128. Ms O'Connor stated that Mrs A would have benefited from dietitian input, given that she was a diabetic with steady weight loss, deteriorating health status and a pressure wound that was not healing. I agree that it would have been beneficial for Mrs A to have been reviewed by a dietitian.

129. EHRV advised that it is not its policy to have every resident reviewed by a dietitian, especially when the GP is involved, as was the situation in this case. Significant loss of appetite, weight loss and poor nutritional and fluid intake increases the risk of developing pressure ulcers and delays wound healing. Monitoring and ensuring adequate food and fluid intake is part of what is required to meet expected standards of care. In my view, staff failed to consider how Mrs A's poor nutrition would affect the healing of the sacral ulcer, and therefore did not meet expected standards of care.

130. EHRV advised HDC that several processes were in place to ensure that the Hospital Manager and/or the Clinical Manager were alerted to care staff concerns about a

[16] See Opinion 08HDC17309.

resident's status. Accordingly, the RNs had many opportunities to raise concerns: during morning and afternoon handover meetings, which were attended by RN D and where changes in residents' health status were discussed; in the daily diary; and, from Month8, at the monthly meetings with RN E. However, RN E told HDC that she knew of Mrs A's sacral ulcer in mid-Month5 but, after that time, no one updated her about Mrs A's condition or reported any deterioration to her. RN D told HDC that after mid-Month8 she was not provided with information from the RNs about Mrs A's ulcer.

131. I consider that there was a lack of communication between the RNs and RN D and RN E about Mrs A's sacral ulcer. Although EHRV advised HDC that the RNs indicated that they had made RN D aware of the deterioration of Mrs A's wound on several occasions, this was not documented. I note the Company's submission reiterating that the RNs had brought their concerns about Mrs A to RN D's attention. However, I remain concerned that communication was lacking in this respect. As stated below, I am also concerned that RN E and RN D failed to adequately assess Mrs A as required by their job descriptions.

132. EHRV acknowledges that despite almost daily contact with a family member, RN D should have communicated better regarding the ulcer's deterioration and treatment. Keeping the resident and family members informed is required, and I consider that the staff at EHRV should have updated Mrs A and her family more regularly about the status of her ulcer.

133. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them.[17] I note the Company's submission that EHRV staff were appropriately supported to raise Mrs A's sacral ulcer as an issue. However, in my view, the failures mentioned above in paragraphs 126 to 131 indicate several failures by multiple staff, and EHRV as an organisation must accept responsibility for Mrs A's suboptimal care.

134. Ms O'Connor advised that the important component missing in the care of Mrs A was the quality perspective. Ms O'Connor said there is no evidence that the sacral wound was followed up from a quality/risk management perspective. If this had occurred then referral to a specialist may have occurred sooner. She stated:

> "Having a responsive system that can provide such specific information, for example longevity of a wound, is a very useful tool. However, it also requires a procedure around who reviews and interprets the reports and what/when action can be taken. This is part of the Quality Improvement process and in this case clinical monitoring. The usefulness of the VCare generated reports would depend on their utilization by staff."

[17] Opinion 07HDC16959 (20 May 2008), page 18, Opinion 10HDC00308 (29 June 2012), page 25.

135. Ms O'Connor commented that the departure from EHRV's policies and procedures in relation to the management of Mrs A's nutritional status and wound care contributed to a moderate deviation from the expected standards of care.

136. I acknowledge that EHRV undertook a thorough investigation into this complaint and has implemented a quality improvement plan. However, I agree with Ms O'Connor that quality systems alone will not ensure that a quality service is provided if the care staff, clinical and/or quality teams are not well versed and vigilant in reviewing the data produced and planning the interventions based on that data.

137. In my view, EHRV failed to adequately assess and evaluate Mrs A's sacral pressure ulcer, monitor her nutritional status and the effect that was having on the healing of the ulcer, and effectively communicate with Mrs A and her family. In addition, there was a lack of communication between the RNs and RN D and RN E about Mrs A's ulcer. Therefore, I consider that EHRV did not take sufficient steps to ensure that Mrs A was provided with appropriate care. Accordingly, in my opinion, EHRV breached Right 4(1) of the Code.

Other comment

138. RN E advised that when she was employed as Clinical Manager, the Company did not employ anyone in her previous position as Rest Home Manager. She felt that this placed an extra strain on her. RN E stated that the Company's Regional Manager and EHRV Village Manager were advised that she felt clinically unsafe; however, she did not document those concerns. I would be concerned if EHRV had been informed that a staff member felt clinically unsafe, and did not take any action to support the staff member.

Opinion: Breach — RN D

139. As Hospital Manager, RN D was responsible for organising the delivery of nursing care and ensuring that care was assessed, planned, implemented and evaluated to meet the residents' individual needs. She was also responsible for keeping doctors informed of each resident's condition and of any deterioration or changes in that condition. RN D was also responsible for acting as an advocate for each resident.

140. While I understand that RN D did not receive a copy of the Hospital Manager job description, she told HDC that she understood that there was very little difference between the two job descriptions, and she understood that she was "primarily responsible for the clinical care provided and non-clinical management in the Hospital part of the facility". She met with RN E each day she was working and, when she was on duty, attended all morning and some afternoon handover meetings with RNs.

141. Mrs A's sacral ulcer first developed on 8 Month5. On 10 Month5 Mrs A was assessed as having a Waterlow score of 28, which indicated that she was at very high risk for pressure ulcers. RN D knew about Mrs A's sacral ulcer in Month5. She told HDC that

she sighted the ulcer in Month6 and Month7, although there is no record of those assessments in the Progress Notes. In addition, RN D advised HDC that a week after returning from leave on 18 Month8 she found out about "the status" of the sacral ulcer. I note that on 17 Month8 it was recorded in the Wound Assessment Plan and Evaluation Form that the ulcer was "worsening" with "macerated skin". Despite knowing that the sacral ulcer had not healed after three months, and was worsening, RN D did not personally examine the ulcer, nor did she evaluate the care of the ulcer herself, until 18 Month10.

142. When Mrs A's nutritional assessment was completed in Month4, it was noted that she scored 5 out of a possible 14. The Nutritional Assessment Form instructed that if a patient scored below 11, the patient was to be referred to the GP or a dietitian. Although Mrs A was started on a dietary supplement at this time, Dr C was not advised about Mrs A's low assessment score, and there was no referral made to a dietitian. Mrs A's weight gradually declined between Month4 and Month10, despite dietary supplements.

143. I agree with my expert nursing advisor, Ms O'Connor, that regularly reviewing a longstanding wound should have been a priority for a person with overall responsibility. RN D said that she asked the RNs looking after Mrs A to advise her when they were dressing the ulcer so that RN D could sight the wound, but the RNs did not contact her about it. However, RN D could have accessed current information about Mrs A's status in the nursing notes and from the RNs working with her.

144. Ms O'Connor also stated that more thorough oversight of Mrs A by RN D would have resulted in the need for further review of Mrs A's nutritional needs, especially for wound healing. Significant loss of appetite, poor nutritional and fluid intake, and weight loss increases the risk of developing pressure ulcers and delays wound healing. There is no evidence in the clinical notes that RN D had any input into Mrs A's care between 31 Month3 and 18 Month10.

145. I consider that RN D should have sighted the wound herself, and should not have relied on the RNs to inform her about the sacral ulcer. She should also have reviewed Mrs A's care herself to determine whether Mrs A's nutritional health was impacting on the healing of the sacral ulcer. Accordingly, RN D was not in a position to keep Dr C informed of Mrs A's condition and any change or deterioration of that condition. RN D accepts that she relied on the RNs to be proactive as far as Mrs A's care was concerned, and to keep her updated. In my view, RN D did not provide an appropriate standard of care to Mrs A.

146. RN D had a personal responsibility to ensure that the care provided to Mrs A was of an appropriate standard. RN D did not review Mrs A's sacral ulcer for at least three months, from Month7 to Month10, and did not evaluate the Wound Assessment Plan and Evaluation Form to determine whether there was any change or deterioration in the ulcer. As a result, RN D was not able to inform Dr C of the change and deterioration in Mrs A's ulcer during Month8, Month9 and Month10. In addition, RN D was not able to communicate her concerns to RN E or Mrs A's family.

Furthermore, RN D did not review Mrs A's nutritional status and consider whether that was affecting the healing of the sacral ulcer.

Summary

147. I am mindful that RN D considered that she was under tremendous pressure and felt clinically unsafe, and that she had informed the Company's Regional Manager and EHRV's Village Manager of those concerns. It does appear that RN D was working in an environment with one less manager than usual, and therefore may have had additional duties. However, I note that she did not document any such concerns at the time.

148. RN D failed to adequately assess Mrs A or evaluate her condition between Month7 and Month10. In my opinion, RN D failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Breach — RN E

149. As Clinical Manager, RN E was responsible for providing "quality resident care" and supervising and delivering nursing care, including the on-going assessment of each resident's care needs and goals. She was also responsible for implementing and reviewing residents' written care plans at regular and appropriate intervals, and for acting as an advocate for each resident. EHRV advised HDC that RN E had the ultimate responsibility for the delivery of services to all residents within EHRV.

150. Mrs A's sacral ulcer first developed on 8 Month5. On 10 Month5 Mrs A was assessed as having a Waterlow score of 28, which indicated that she was at very high risk for pressure ulcers. RN E knew about Mrs A's sacral ulcer in mid-Month5. She told HDC that after that time she did not have any discussions with the RNs or RN D about Mrs A's ulcer because "the deterioration was never reported to [her] or raised in any clinical meetings or elsewhere".

151. In my view, given her job description, RN E had a responsibility to ensure that the care provided to Mrs A was of an appropriate standard. RN E did not ever review Mrs A's sacral ulcer, did not at any time review the clinical notes, including Mrs A's care plan, and did not evaluate the Wound Assessment Plan and Evaluation Form to determine whether there was any change or deterioration in the ulcer.

152. I am mindful that RN E considered that she was under extra strain and felt clinically unsafe, and that she had informed the Company's Regional Manager and EHRV's Village Manager of those concerns. It does appear that RN E was working in an environment with one less manager than usual, and therefore may have had additional duties. However, I note that she did not document any such concerns at the time.

153. I note RN E's submission that it was a practical impossibility for her to be aware of the care being provided to every patient and resident at EHRV. I have considered RN E's response carefully, but remain of the view that she failed to ensure that Mrs A was

adequately assessed or evaluated as required by her job description. In my opinion, RN E failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Adverse comment — Dr C

154. Dr C reviewed Mrs A on 10 Month10 and noted the deterioration and concerning state of her sacral ulcer, ordered a swab, and noted that he was to review Mrs A on 17 Month10. He said that he viewed the laboratory generated swab test result and advised the RN assisting him on 17 Month10 that Mrs A did not require antibiotics, but he omitted to see Mrs A because her file was not on the ward-round trolley, and the RN did not remind him that he had planned to review Mrs A that day.

155. My expert advisor, Dr David Maplesden, was critical that, given the state of the ulcer on 10 Month10, Dr C did not review the ulcer on 17 Month10 with or without prompting from the RNs. However, Dr Maplesden considered that otherwise Dr C's management of Mrs A was consistent with expected standards.

156. I have considered Dr C's submission that he has to rely on administration and nursing staff at EHRV to advise him of who requires a consultation or follow-up. However, I remain concerned that, given the seriousness of Mrs A's sacral ulcer, Dr C did not review her as planned.

Recommendations

157. In my provisional opinion, I made the following recommendations:

1. RN D to provide a written apology to Mrs A's family for her breach of the Code.
2. RN E to provide a written apology to Mrs A's family for her breach of the Code.
3. EHRV:
   - to provide a written apology to Mrs A's family for its breach of the Code;
   - to amend the policies regarding the management of pressure areas to ensure that all wounds of two months or more are reviewed by a wound specialist or GP;
   - to amend the Wound Management Policy to identify who is responsible for reviewing the information provided by the VCare reports; and
   - to arrange for an audit of the policies developed in the quality improvement plan (and as amended above) and staff training in those policies, and report the results of that audit to this Office within three months of the date of my final opinion.

158. In response to my provisional opinion, RN D provided a written apology to Mrs A's family.

159. In response to my provisional opinion, EHRV provided a written apology to Mrs A's family, and advised that:

- it has amended its Wound Management Policy to ensure that all wounds of two months or greater duration will be reviewed by a wound specialist or GP;
- it has amended its Wound Management Policy to identify a staff member responsible for reviewing the information provided by the VCare reports;
- an audit has been arranged for 11 and 12 September 2013 to focus on the policies developed in the Quality Improvement Plan and staff training in those policies.

160. As per my provisional recommendation 2, I recommend that RN E provide a written apology to Mrs A's family for her breach of the Code. The apology is to be forwarded to HDC by **12 July 2013** for sending to Mrs A's family.

Follow-up actions

161.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Edmund Hillary Retirement Village Limited, will be sent to the Medical Council of New Zealand, and the Council will be advised of Dr C's name.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Edmund Hillary Retirement Village, will be sent to the Nursing Council of New Zealand, and the Council will be advised of RN D's and RN E's names.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Edmund Hillary Retirement Village, will be sent to the DHB, the Ministry of Health, the College of Nurses Aotearoa Inc, and the New Zealand Aged Care Association, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from Margaret O'Connor, a registered nurse with expertise in care of the elderly:

Preliminary Expert Advice (18 August 2011)

"**Provisional Report re Complaint: Edmund Hillary Retirement Village**
Ref: 11/00471
I have been asked to provide preliminary advice regarding the care provided to the late [Mrs A] at Edmund Hillary Retirement Village (EHRV).

Background
[Mrs A] was admitted to EHRV [in] 2007. Her medical history included: Parkinson's disease, dementia, osteoporosis, recurrent UTI's, postural hypotension, Type 2 diabetes, incontinence and poor vision.

On [18 Month4], a pressure area was first noted on [Mrs A's] sacral area. It was managed with bed rest and two hourly turns. This was noted to heal on [24 Month4] only to reoccur on [8 Month5]. Over time it became progressively worse.

On [10 Month10] she was seen by her General Practitioner (GP) for a three monthly review and was noted by the GP to have a very deep necrotic 3cm diameter sacral pressure ulcer which had slowly increased over the past five months. Swabs were taken. No other changes were made to the treatment plan. A 4kg weight loss over the last three months was also noted.

On [18 Month10] a request was made to the GP for urgent referral for debridement of the ulcer as [the public hospital] wound care specialist had recommended that [Mrs A] be admitted. She was transferred to [the public hospital] on [21 Month10].

However, the decision was made not to surgically treat [Mrs A] and she was discharged. [Mrs A's] family decided not to return [Mrs A] to EHRV.

[Mrs A] has since died. Her death certificate lists sacral ulceration as one of the causes of death.

The documentation I have reviewed includes

1. The letter of complaint from [Mrs A's] grandson, [Mr B].
2. Response from [the Company] dated […].
3. Quality Improvement Plan from [the Company] dated […].
4. Progress notes
5. Wound assessment, medical assessment and nursing assessment forms.
6. Relevant policies and procedures.
7. Information on staff education and inservices.

8. Copies of correspondence with [Mrs A's] family in relation to their complaints.

Pressure area risk assessment
Waterlow scores are 6 monthly recorded as per policy. On [4 Month10] and [18 Month4] the scores were recorded as 20 and 23 respectively. On [10 Month5] and [13 Month10] they were 28 and 30 respectively. I note changes to the form were made between the two sets of recordings. In all of these assessments the turning regime and equipment used, i.e. air alternating mattress, were not recorded. [Mrs A's] care plan formulated on [16 Month5] identifies the use of a pressure relieving mattress and position change every 2 hours when she is in bed; this regime is also mentioned in her progress notes and is appropriate.

Wound care
[Mrs A] was noted by [the Company] in their investigation to have had previous pressure areas; on her left heel [in mid 2009], right pinna (ear) [24 Month1] and [27 Month3] a small sacral pressure area. Interventions recorded were timely and appropriate. On [24 Month3] the Geriatric Nurse Specialist from [the DHB] was consulted for advice on dressing for the left heel. The left heel was noted to be improving on [17 Month4] and resolved [21 Month4] and on [24 Month4] the sacral wound healed.

According to [the Company's] summary of [Mrs A's] notes the sacral pressure area reoccurred on [8 Month5]. A Wound Assessment Plan and Evaluation form was completed by [an RN] on [8 Month5] and describes the wound to be 4cm by 2cm with no depth i.e. superficial. There is no incident form evident which should have been completed as per policy. Nor is there evident any VCare documentation where the development of the pressure ulcer is to be recorded as a 'resident incident'. This assessment form was reviewed on [6 Month5], [10 Month7] and [20 Month7]. Another form was completed on [17 Month8] by [an RN] and describes the wound as 6cm x 3cm and 2cm deep. This was reviewed on [6 Month10] and [15 Month10]. The ongoing plan and evaluation forms provide evidence of care provided to the wound as planned. The instructions provided for wound care are evidenced as being completed. Dressings to the ulcer seem appropriate in product choice and length of time between dressings.

According to the wound ongoing plan and evaluation pages and the progress notes the ulcer initially, on [6 to 26 Month6], showed signs of improving then gradually increased in size and depth till it was noted to be necrotic on [5 Month10] and was referred to the GP for review. A wound swab was taken [10 Month10] which cultured a heavy growth of mixed aerobic and anaerobic flora. On [14 Month10] the wound was noted to be odorous and increasing in size. More objective data, i.e. regular measuring, may have shown that the ulcer had accelerated in size, depth and appearance during [Month9] and [Month10] and this may have corresponded with a deteriorating health status following a possible Stroke on [12 Month8] (on [20 Month8] serial blood tests showed that a diagnosis of Myocardial infarction could not be made.

Policy states 'appropriate specialist advice is to be sought as assessed as necessary by the Registered Nurse'. Although ongoing assessment by a registered nurse did occur there is no evidence of referral for specialist advice until [Month10] approximately 6 months after it redeveloped. There is no evidence of what is done with the information that would have been collected on the initial incident form and how the wound is followed from a Quality/Risk management perspective. If information regarding unresolved wounds is collected then EHRV may have identified through its quality processes that the ulcer was unresolved and maybe needed specialist follow up. I do note the Clinical Manager was involved [12 Month8]. I also note that the policy and procedures I have reviewed were modified on [after the complaint period].

Nutritional status

A Nutritional Assessment Form was commenced on 6 July 2009 due to gradual weight loss by a dietician. [Mrs A] was trialled on Diasip which she liked and a special benefits number was applied for which is very appropriate. [Mrs A's] weight increased to 46kg by [24 Month3]. There is no further evidence of dietician input after this date. A Nutritional assessment completed in [Month4] records [Mrs A's] weight as 45.5.kg and gives her a score of 5. Instructions on the form advise to refer to GP or dietician if score is 11 or less. [Mrs A] should have been referred back to the Dietician for ongoing input on this basis. A notation made on [13 Month5] which records [Mrs A] on Diasip twice daily unfortunately no amount is evident. The same assessment was completed on [13 Month10] and a score of 1 is recorded.

Weight is recorded and commented on monthly. Comments on her weight and reasons for loss are evident monthly from [Month4]. A gradual weight loss is evident [Month4] to [Month10] despite supplement feeding. It is noted in [Mrs A's] progress notes that she began refusing food on occasions from [17 Month9] onwards. A 4kg weight loss in last 3 months was noted by the GP on [10 Month10].

Diabetic status

I am unsure of [Mrs A's] blood sugar levels which according to her care plan were being done monthly. Her HbA1c was recorded in the Medical notes on [16 Month7] as less than 5.5 which is within an acceptable range. Good diabetic control will aid wound healing.

Staff training

The following related staff training has been evidenced as provided in the year prior to the complaint

- [2009] — Providing culturally safe care and Maori health Plan.
- [2010] — 20 minute session was held on new mattress and air cushion and heel protectors.
- [2010] — 45 minute session was held on wound management using Hartman products.
- [2010] — A death and dying notice was given to all staff with their pay slip reminding them of correct procedure.

- [2010] — 40 minute session on the 'Path of Grief'.
- [2010] — 1 hour on grieving and the trauma of death.
- [2011] — Palliative care 50 minutes.

Since the investigation EHRV report that they have provided training on: advanced directives and professional conduct, palliative care and LCP, wound management and pressure care for caregivers, study day for registered staff which included pressure area, wound healing and nutrition and wound healing and management, providing personal care including skin care and pressure sores, a LCP refresher, use of the Niki T34 syringe driver and a 3 hour session on assessing and grading pressure areas.

Response to concern and complaints
There is well documented dialogue with family and staff regarding any concerns in [Mrs A's] care provision both in the progress notes by registered staff and by written responses to 5 previous concerns by management.

The ARRC services agreement requires providers

D16.3
f. Each subsidized resident and his or her family/Whanau have the opportunity to have input into the Subsidised Resident's care planning process;

D16.4 Evaluation
b. You must notify the Subsidised resident's family members, with the Subsidised Resident's consent, as soon as possible, if the Subsidised residents' condition changes significantly;

[The Company] in their investigation state 'all changes and interventions were advised to family and, as able, a family member was in attendance with [Mrs A] for health consultations'. Progress notes repeatedly show evidence of family being informed or being involved in consultations. [Mrs A's] daughter [Mrs F] was obviously very involved in her mother's care and also acted as an interpreter between [Mrs A] and staff as [Mrs A] [did not speak English]. [Mrs F] was reported as viewing the wound on [20 Month5] but not since. [The Company] acknowledges 'that the family were not aware of the extent of the sacral breakdown and on reflection we could have visually shown the family the wound site'.

[Mr B] outlines in his letter an incident with [a registered nurse] and his mother on [11 Month8]. I can find no documentation that this was reported to EHRV by [Mrs F] and therefore dealt with appropriately. There is other evidence in the progress notes that [Mrs F] has felt on occasion that she was not treated appropriately by staff. On [18 Month3] [Mrs F] commented that some carers were rude to her and on [20 Month4] [Mrs F] commented that staff were being unwelcome to her. On this occasion the RN involved 'discouraged [Mrs F] from raising her voice in [Mrs A's] room as it affects her mother, to speak to staff away from the room, to which [Mrs F] agreed'. The policy 'Recognition of Individual Values and Beliefs' is very specific around open communication and cultural sensitivity.

Improvements made by EHRV since complaint investigated
[The Company] and EHRV management are to be commended on their own investigation into this complaint and the subsequent quality plan they have formulated to address the issues they identified. The Quality Plan appears very extensive and thorough and perhaps the only recommendations I could add to this are

- Change procedure to ensure a new Assessment form is completed for each review giving a new wound description.
- Map wounds at regular intervals giving objective data on size, depth and presentation.
- Use photographs to give a chronological record of wounds.
- Also use photographs as a visual tool for keeping family informed.
- Adjust policy and procedure to ensure wounds are reviewed by the facility wound specialist and referred to specialist services if not healed within a specific time frame.
- Presence of wounds, both new and existing is monitored by either the clinical management or Quality/Risk Management team as a key performance indicator.
- Signatures of staff are legible or have their printed surname next to them at least once a page.

Summary
I agree with [The Company's] statement in 'regards to the sacral pressure area, we acknowledge that from [Month8] more robust intervention should have been implemented and the deterioration of the wound better evaluated with more effective communication with [Mrs A's] family'. I also agree that [Mrs A's] health appeared to be 'appropriately monitored and documented' in the evidence I have reviewed except for her nutritional status after [24 Month3]."

Further comment (1 November 2011)

"Provisional Report re Complaint: Edmund Hillary Retirement Village
Ref: 11/00471

In response to your request for advice on the severity of departure from expected standards of care for [Mrs A] I would like to make the following points.

The important component missing in the care for this lady was from a quality perspective. There is no evidence that the sacral wound was documented using an incident form or a VCare form and followed up from a Quality/Risk Management perspective. If this had occurred then referral to a specialist may have occurred sooner.

Also, the facilities policy and procedure was not followed in referring [Mrs A] for dietician input and this may have had an affect on the wound growth.

It is this departure from policy and procedure which has possibly contributed to the deviation from expected standards of care for this lady. Collectively I find this departure to be moderate."

Further advice (11 June 2012)

"I have been asked to provide expert nursing advice regarding the care provided to the late [Mrs A] at Edmund Hillary Retirement Village (EHRV) from [Month4] until her transfer to acute care on [21 Month10].

Professional profile

Since registering as a Comprehensive Nurse in 1988 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2009). My initial nursing experience was as a Public Health Nurse after which I moved to the hospital setting first in orthopaedic nursing then acute/general medical in a rural hospital. Following this I embarked on an overseas trip where I worked firstly as an agency nurse in various hospital wards then in the community setting as a district nurse in London. Also in London, I worked for 9 months in a Nursing Home for older people before returning to New Zealand and commencing nearly 5 years in Assessment, Treatment and Rehabilitation. In this setting, I coordinated a 12 bed unit and completed needs assessments for older people in a large geographical area. From 1997 to 2011 I worked for a non-profit charitable organization managing various aged care facilities. Most recently I managed a retirement village of 60 beds; residential, hospital and dementia levels, and 21 cottages. I was chair of the facility's Quality team and the organization's Clinical Practice Group and managed my facility through many changes in care provision and enjoyed successful audits. Currently I am a Nurse Practitioner Candidate for Older Persons Health in a joint initiative between a District Health Board and a non-profit charitable organization. I am a member of the New Zealand College of Nurses and enjoy providing education and insight into care of the older person for various groups in my region.

Background

As set out in the preliminary advice.
The documentation I have reviewed includes

1. The letter of complaint from [Mrs A's] grandson, [Mr B].
2. Response from [the Company] dated […]
3. Quality Improvement Plan from [the Company] dated […].
4. Progress notes.
5. Wound assessment, medical assessment and nursing assessment forms.
6. Relevant policies and procedures.
7. Information on staff education and inservices.
8. Copies of correspondence with [Mrs A's] family in relation to their complaints.
9. Letter from [the Company] dated 8 December 2011, with listed attachments, marked 'A', pages 1–111.
10. Letter from [Dr C] dated 6 December 2011, marked B, pages 112–116.

11. Response dated 24 April 2012 containing Policies 4.157, 4.59, 4.62, 4.171, 4.39, 4.78, Registered Nurse (RN) Job description, RN/EN Clinical Induction index and [Mrs A's] DNR form.

I have been asked to specifically comment on

1. The failure of nursing staff to refer [Mrs A] to a dietician.
2. The adequacy of the incident forms and VCARE documentation in light of Herb's advice that it was not policy for a new incident form to be commenced for pathological wounds.
3. Whether EHRV had adequate policies and guidelines in place in relation to the management of pressure areas, particularly in relation to the responsibility for referral to the GP or wound care specialist.
4. The adequacy of action EHRV has subsequently taken.

1. The failure of nursing staff to refer [Mrs A] to a dietician

A Nutritional Assessment Form was commenced on 6 July 2009 due to gradual weight loss by a dietician. [Mrs A] was trialled on Daisy which she liked and a special benefits number was applied for which is very appropriate. [Mrs A's] weight increased to 46kg by [24 Month3]. There is no further evidence of dietician input after this date. A Nutritional assessment completed in [Month4] records [Mrs A's] weight as 45.5.kg and gives her a score of 5. The same assessment was completed on [13 Month10] and a score of 1 is recorded. Instructions on the form advise to refer to GP or Dietician if score is 11 or less. There is no mention of this assessment or the need for Dietician input being discussed in the GP's notes from his visits or the progress notes. However the GP does record his weight reviews. On [13 Month5] [Mrs A's] notes record she was prescribed Daisy twice daily unfortunately no amount is specified. Weight is recorded, commented on and reasons for loss are evident monthly from [Month4] by the RN's. A gradual weight loss is evident [Month4] to [Month10] despite supplement feeding. It is noted in [Mrs A's] progress notes that she began refusing food on occasions from [17 Month9] onwards. She continued to be offered Daisy on an ongoing basis but there is no evidence of what she actually took.

In his statement the GP says that in 2009 a referral to the Dietician was done and [Mrs A's] weight remained stable for the next 12−18 months. During a review on [16 Month7] he noted that 'her weight was relatively stable'. He next visited her urgently on [13 Month8] when he was told 'in passing' by nursing staff that she had a pressure area. He was not asked to review her again until her regular 3 monthly review on [10 Month10]. During this visit he has noted that [Mrs A] had lost 4kg since his last 3 monthly reviews. He stated in his reply that his request to review [Mrs A] again on [17 Month10] was not recorded in the appropriate diary and he subsequently did not remember to review her. After reviewing the Hospital Manager Job Description I assume it would probably have been her responsibility to ensure this occurred as part of the responsibility of co-coordinating the Doctor's visits. I am also assuming that the Hospital Manager would have also been responsible for discussing the need for a Dietician's input for this lady with the GP.

[The Company states] that it is not their policy to have every resident reviewed by a dietician especially when the GP is involved and that the GP was aware of [Mrs A's] nutritional status and deteriorating condition. I am assuming they are referring to the GP's comments that are recorded around the time of the health event of [13 Month8] from which [Mrs A] recovered to a certain extent. Her swallow improved and on [28 Month8] the recording of her fluid chart was ceased and she was noted to have 'improved a lot'. The relevant question is whether [Mrs A], a Diabetic with steady weight loss and deteriorating health status and wound, would have benefited from Dietician input given that a Dietician can recognize and plan nutrition requirements.

Perhaps with more thorough clinical oversight from the Hospital Manager the need for further review of her nutritional needs, especially for wound healing, may have been recognized. However the Hospital Manager in her meeting with EHRV management on [11 Month11] stated nobody had told her of [Mrs A's] decline when she returned from leave on [18 Month8]. There is no evidence in the progress notes of her having input into this lady's care from [31 Month3] till [18 Month10] when she assisted with [Mrs A's] transfer out. I fail to understand how this occurred given that the Hospital Manager's responsibilities (as outlined in the Job description) include reviewing residents in her care with nursing staff on a day to day basis. Regularly reviewing a longstanding wound, and associated needs, should have been a priority for someone with overall responsibility.

If the Hospital Manager had acted on up to date knowledge of this lady's needs, gained from her documentation and registered staff working with her and clinical assessment, then perhaps she could have further communicated with family, kept them fully informed and facilitated decisions around her care. A family meeting to outline objectives of care, particularly after recovering from the 'health event' in [Month8], would have been useful both for staff and [Mrs A's] family and facilitated discussion around the presence of the wound and its treatment.

There appears to have been some communication issues between the RN's working in this area and the Hospital Manager. The RNs felt they reported their concerns that the wound had 'deteriorated beyond their scope of expertise' ([24 Month11]). However, I find no written evidence of this. I have not reviewed any handover documents or minutes of any clinical meetings that may have discussed [Mrs A's] health needs.

2. The quality process for recognizing long standing wounds

I am unfamiliar with the Care system and how it relates to the tracking of ongoing wounds. I understand from the Care website (http://www.vcare.co.nz) that it formulates the resident's long term care plan and logs and records information on separate incidents. It also claims to generate a report of incidents and a list of unresolved events. Herb's Incident form requests incident details for VCARE of 10 words or less to be entered on computer. Among other details it also asks if the next of kin has been notified. Overall, it appears to request adequate information.

I have reviewed policies

• 4.247 — Principles of wound management

• 4.204 — Skin Integrity — Management of and risk to pressure areas.

[The Company states] that it was not 'specific policy' to complete incident forms for pathological wounds and thus entering their presence into the Care process. 4.204 now states that all identified pressure areas must be recorded on an incident form and entered into Care. This was modified [after the complaint]. I note that despite previously not requiring staff to do this there were incident forms generated for a sacral wound on [27 Month3] and [18 Month4] by the same RN.

Having a responsive system that can provide such specific information, for example longevity of a wound, is a very useful tool. However it also requires a procedure around who reviews and interprets the reports and what/when action can be taken. This is part of the Quality Improvement process and in this case clinical monitoring. The usefulness of the VCARE generated reports would depend on their utilization by staff.

The incident forms that I have reviewed request details for VCARE entry but there is no space for anyone to note that the details have been entered. Page 2 of these completed documents has not been supplied. I note that this has been added to the modified version and on the 'Wound assessment plan and evaluation form' modified on 31.5.12. These forms appear to be adequate.

The Care generated Long Term care plan for [Mrs A's] Skin wound and pressure care was generated on [30 Month4] and the presence of the sacral pressure ulcer was recorded in hand writing on [23 Month9]. This was probably because the Policy states that this care plan only gets updated every 6 months. The specific instruction for care and evaluation of the wound is found on the 'Wound assessment plan and evaluation form'. This was first generated on [8 Month5] and updated on [17 Month8]. The ongoing plan and evaluation form was dutifully maintained by the RN's.

There is no evidence that the Hospital Manager or anyone other than the RN's reviewed or discussed [Mrs A's] wound. As previously stated the RN's say they verbally escalated their concerns upwards and the Hospital Manager admitted in her meeting with EHRV that she had knowledge of [Mrs A's] deterioration but 'didn't do anything about it'.

Systems such as Care require staff, clinical or quality teams, who are well versed and vigilant around reviewing the data it produces and planning interventions based on that data.

3. Adequacy of policies and procedures regarding management of pressure areas

As discussed earlier I have reviewed policies, 4.247 and 4.204 that pertain to management of skin integrity and pressure areas. These had been modified [post-complaint]. Also the Wound assessment plan and evaluation and ongoing plan and evaluation forms.

4.204 states that all hospital residents' skin integrity is assessed with Waterloo at admission and when needs change or at least 6 monthly, this is appropriate. This policy also outlines the appropriate use of aids, position changes and skin management.

Given that pathological wounds were not incident formed I cannot find any reference in [Company] policies that deals with the recognition of longevity of wounds and timing of GP/specialist referral. 4.247 states that

I. Appropriate advice can be sought as assessed necessary by the RN.
II. New documentation must be completed when there is any change in grade or presentation.
III. There is provision for photographic documentation of the wound.
IV. Appropriate advice can be sought as assessed necessary by the RN.

The 'Wound assessment, care plan and evaluation form' both have prompts for referral to GP, Infection Control Nurse and Wound Management Specialist. However this was not utilized on [17 Month8] despite the severity of the wound. Given the contents of the policy as outlined above perhaps the RN filling out the form should have considered seeking 'appropriate advice' or if she had with the Hospital Manager recording that she had done so.

The report by [DHB Funding and Planning] on 5 December 2011 identifies that EHRV had appropriate systems and practices in relation to the prevention and management of pressure areas. My review of the related Policies and procedure has identified that they appear to outline adequate processes around the management of pressure areas except for:

1. ensuring all longstanding wounds e.g. 2 months or more, are reviewed by a Wound specialist regardless.
2. identifying who is responsible for reviewing the follow up information provided by the VCare reports.

I do recommend the RN's more fully document conversations around care to ensure appropriate accountability for planning, intervention and evaluation of care.

4. Adequacy of action EHRV has subsequently taken

[The Company] and EHRV have instigated an intensive investigation of their own into this complaint and implemented a Quality Improvement plan dated [1 Month11] which includes planning for

- reviewing all current wounds
- appointment of overseer for all wounds
- in-service on wounds and management
- pressure area care with caregiver education on communication and accountability
- education on continence management
- changes to GP services

- internal spot audit and continuing internal audits
- following of [the Company's] accreditation program calendar
- introduction of quality assistant support 2 days per week
- introduction of nurse advisor 2 days per week
- staff survey and VARCE survey
- RN seminars held for pain, wound care and antipsychotic medications and relative meetings
- RAP calendar for RN in-service and attend [DHB] study day
- Focused training for caregivers on personal cares
- Focused training for housekeepers
- Focused training on cultural awareness and communication
- Focused daily meetings to review residents with wound care, falls, pain, infections, pressure sores, weight loss and deterioration requirements
- VCARE system utilization
- Continuation of staff orientation, induction and ACE and Career force programs
- Infection control standard precautions training.

[Ms L] outlines training completed to 31 November 2011 on p2 of letter dated 8 December 2011 to HDC which includes those planned as above as being provided.

They have met with [Mrs A's] family on several occasions and offered apology for their shortcomings in not keeping them fully informed of the extent of the pressure area.

They have participated in an Issues Based Audit onsite for 2 days. The Report by [the DHB Funding and Planning] on 5 December 2011 identifies that EHRV have strengthened systems since the complaint 'to promote adequate monitoring of residents and that changes in their condition were acted on' (p84). This includes ensuring all wounds are now incident formed and subsequently entered into the VCARE system.

They have completed an investigation into the Hospital Manager's performance and subsequently reported her to New Zealand Nursing Council for investigation into the competency issues they found. It is indeed unfortunate that it took a complaint of this seriousness to recognize the Hospital Manager's performance issues.

In summary I feel that EHRV and ultimately [the Company has] been very thorough in their approach to this complaint and their compliance with the investigation. They have appropriately identified areas of concern and responded accordingly. One area of concern remains around the referral to the dietician.

May I also recommend that staff are reminded of their responsibility to use legible signatures as part of the Health and Disability sector standard requirements.

Margaret O'Connor, RN, MN,
5 June 2012"

Appendix B — Clinical advice to the Commissioner

The following clinical advice was obtained from independent general practitioner Dr Dave Maplesden:

"My name is David Maplesden. I am a vocationally registered general practitioner practicing in Hamilton, New Zealand. My qualifications are MB ChB (Auckland University 1983), Dip Obst (1984), FRNZCGP (2003).

1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided to his grandmother, [Mrs A] (dec) by [Dr C] in his capacity as her attending GP at Edmund Hillary Retirement Village (EHRV). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. Much of the complaint relates to the nursing care of [Mrs A], and I understand a review of this care has already been undertaken. At issue is [Dr C's] management of [Mrs A], particularly in relation to management of a sacral pressure area that was first evident in [Month3], and that he did not view until [10 Month10] when it was well advanced. I have reviewed the information on file: complaint from [Mr B]; response from EHRV (per [the Company]); response from [Dr C]; EHRV care documentation including specific wound care notes; [the public hospital] notes.

2. EHRV Caregiver progress notes summary (relevant references)
(i) [14 Month3] — pressure area left heel noted by carer. Flucloxacillin commenced [17 Month3] after review by [Dr C]. [27 Month3]— small pressure area noted on sacrum — daughter notified. [17 Month4] — reference to pressure area heel (side not defined).

(ii) [18 Month4] — reference to *pressure area starting to build up on [Mrs A's] sacrum…two hourly turns implemented*. On [24 Month4] *pressure area on sacrum healed already.*

(iii) [8 Month5] — sacral pressure noted, refer to wound care chart. Two-hourly turns to be done when in bed.

(iv) [12 Month8] — [Mrs A's] daughter concerned at her mother's condition — chest pain, dizziness, very poor appetite. Vital signs stable, possibly some response to GTN spray. GP visit arranged for next day. [13 Month8]: *Seen by GP re family concerns on [Mrs A's] health deterioration, poor swallowing food/fluid intake decline…GP discussed with family possible causes of decline ?TIA. lab test requested. To commence on food/fluid intake summary.* Blood tests showed mild troponin elevation — *GP notified and to be repeated in one week.*

(v) [4 Month10] — [Mrs A's] daughter *requesting a review of her mom's medication for Parkinsons — sinemet. To let GP know on next visit.*

(vi) [10 Month10] — *Seen by GP for her 3-monthly review … sinemet dose reduced…swab of sacral pressure sore sent to lab as requested by GP. No other*

changes made. [14 Month10] — *faxed copy of preliminary* [wound swab] *result sent through for [Dr C] to review in his next clinic…*

(vii) [18 Month10] — *request for urgent referral to the public hospital for debridement of sacral pressure area faxed to [Dr C]* [in response to communication from DHB Wound Care Nurse Specialist (WCNS) who could not visit until the following week but felt the sacral wound required more urgent attention]. At 1115hrs — *followed up with a call to [Dr C's] rooms to convey the above recommendations* [[Dr C] denies receiving any call and there is no note at his rooms of a call being received].

(viii) [19 Month10] — *contacted [Dr C] about worsening of sacral wound, very odorous now and causing pain when dressing is done. [Dr C] will contact the surgical registrar at [the public hospital] & get back to us.* Transferred to *[*the public hospital*]* on [21 Month10] as arranged.

(ix) While there are frequent references to the sacral wound in the care notes, there is no documented indication that the wound was brought to [Dr C's] attention prior to [10 Month10]. There is little indication from the notes that [Mrs A] was suffering increasing pain from the wound until the comment on [19 Month10].

3. EHRV Nursing Wound Assessment and Evaluation documentation:
(i) Entry dated [8 Month5] notes a 4x2cm sacral wound, daily dressings and 2-hour turns when in bed were instigated. There was initial improvement in the wound but in early [Month6] it was noted to be increasing in size, then started improving again, then slowly worsening.

(ii) From about [mid-Month7] the wound is described as either slowly increasing in size or stable. Wound swab was taken on [21 Month9] (nursing staff) and reported [24 Month9] as showing small number of white cells but large number of mixed bacterial flora on microscopy and gram stain, and heavy growth of mixed aerobic and anaerobic flora on culture.

(iii) On [7 Month10] the wound is reported as worsening, *surrounding skin macerated, odorous, mod serous ooze.* GP review on [11 Month10] is noted and swab taken on that day. This was reported on [14 Month10] as showing no white cells but large number of mixed bacterial flora on microscopy and gram stain, and heavy growth of mixed aerobic and anaerobic flora on culture.

(iv) From [13 Month10] the wound is reported as being *odorous* and increasing in size. On [17 Month10] the comment is recorded *Redressed…swab result seen by GP, no further interventions.* There are comprehensive entries on [18 and 19 Month10] commenting on the extent of the wound and [Mrs A's] risk factors and on [19 Month10] the notes record *Urgent referral done to GP by…Hospital Manager. Awaiting GP's reply.* On [21 Month10] admission to *[the public hospital]* is noted.

4. [Public hospital] notes summary

(i) [Mrs A] was admitted on [21 Month10] with a large, offensive smelling, necrotic sacral pressure ulcer. She was afebrile and vital signs stable. She was treated with IV fluids and on [22 Month10], in conjunction with the family, a decision was made not to offer surgical debridement of the lesion in view of the extent of debridement required and [Mrs A's] co-morbidities, age and poor quality of life. Comfort/palliative cares were instituted and simple dressing applied to the ulcer.

(ii) Swabs taken on [21 Month10] gave results unchanged from the [Month9] and earlier [Month10] results, MRSA screen was negative and there was no Staphylococcus aureus, beta-haemolytic Streptococci or Pseudomonas isolated.

(iii) I note a decision was recorded on [23 Month10] for [Mrs A's] death certificate to read *I (a) sepsis (b) necrotic sacral pressure sore (c) Parkinson's disease, Dementia.* I could not see that [Mrs A] was showing any signs of systemic sepsis at the time this was recorded, and note she was discharged from [the public hospital] on [31 Month10] to an alternative long-term care facility where [she died]. I cannot comment on the accuracy of the causes of death as listed on the death certificate as I have no documentation relating to the period following her discharge from [the public hospital].

5. GP response and notes

(i) [Dr C] visits EHRV on a weekly basis. He sees patients booked for routine 3-monthly review (scheduled by nursing staff) and any patients with problems requiring more urgent review outside the 3-monthly standard review period. He relies on nursing staff to triage and schedule these urgent reviews.

(ii) [Dr C] has outlined his care of [Mrs A] since her admission to EHRV in [2007] (see GP response), and her co-morbidities. The details will not be reiterated here but the contemporaneous GP documentation is consistent with the response. The standard of documentation is generally good. There has been regular diabetes surveillance with HbA1c at least quarterly and always showing excellent control. Renal function and blood count were checked generally once or twice a year and were unremarkable.

(iii) [Mrs A] was seen at least monthly in the first year of her admission to EHRV and [Dr C] has given an accurate recounting of these attendances in his response. Treatment on each occasion appears consistent with expected standards. From September 2009 [Mrs A's] condition was deemed stable and routine visits changed to 3-monthly although she was actually seen, or treatment discussed, on 17 occasions over the next 12 months. Again, assessment and treatment over this period has been well documented and is consistent with both [Dr C's] response and with expected standards.

(iv) Between September 2009 and [Month4] there were nine GP attendances. The pressure area on [Mrs A's] right ear was assessed on [24 Month1] and treated with topical antibiotics. Left heel pressure area was treated with oral antibiotics on [17 Month3]. Dietary supplements were being prescribed for weight loss and poor

nutrition. Issues of possible ischemic chest pain and TIA were dealt with appropriately.

(v) At 3-monthly review on [16 Month7], [Mrs A's] diabetes control is excellent, weight still decreasing and vital signs stable. There is no mention of a sacral pressure area. I am mildly critical that a further nutrition assessment and dietician review was not recommended at this point, although it could be argued this is primarily a nursing activity and should have been instigated by the RN (there had apparently been a nutrition assessment in [Month4] that indicated sub-optimal nutritional status but a dietetic assessment was not undertaken at that point).

(vi) [Dr C] reviewed [Mrs A] on [13 Month8] because of recent chest pain and unwellness. She appears recovered by the time of the assessment but a reasonable examination is documented, blood tests ordered and fluid balance recording advised. Current management is reviewed including *2 hrly turning (has a pressure sore). Review prn.* [Dr C] states there was no indication given to him by nursing staff that the pressure sore required a specific assessment or was extraordinary in any way. Blood test results have been reviewed on [20 Month8].

(vii) On [10 Month10] (routine review) [Dr C] has recorded *Has a very deep and necrotic 3cm diameter sacral pressure sore — started 5/12 ago & slowly increasing in size despite expert nursing care — 2hrly turns/air mattress/dressings. Patient appears to have some pain from [the ulcer]. Plan: 1. Swab then [Dr C] R/V next wk 2. No other changes @ moment except for ↓ frequency of Sinemet as requested by daughter. NB 4kg weight loss last 3/12.* This management was reasonable under the circumstances. Infection can certainly contribute to sudden deterioration of a pressure area. Recent HbA1c ([7 Month10]) showed excellent diabetic control. Poor nutrition was likely to be a factor contributing to poor healing and would require addressing once infection had been treated or excluded. [Dr C] has not documented reviewing the wound swab result (available to him [14 Month10]) and did not undertake the scheduled review on [17 Month10]. [Dr C] states the review was not undertaken because nursing staff had not scheduled it. The Wound Care Notes (see below) are somewhat at variance with his response, indicating the wound swab result was reviewed by him and no further action was to be taken. The swab result was probably more indicative of superficial wound contamination rather than significant infection, although sometimes culture of wound biopsy is required to determine if significant infection is present. [Mrs A] was evidently not exhibiting any symptoms to suggest systemic sepsis. Under the circumstances, antibiotic treatment was not obviously indicated, which meant some other intervention would be required to aid wound healing — that being referral for wound debridement and improving [Mrs A's] nutritional status. Given the state of [Mrs A's] sacral pressure area when [Dr C] viewed it on [10 Month10], I find it somewhat puzzling that he did not think to review it again with or without prompting from the nursing staff, particularly if he had viewed the wound swab result. Noting he had a documented intention to review the wound, but may have overlooked this because he did not receive prompting from nursing staff, his failure to review the wound on [17

Month10] was probably a mild departure from expected standards unless he was aware there was imminent review by the WCNS (when I would not regard it as a significant departure). The events of [18 Month10] remain unclear — I cannot determine whether [Dr C] received the faxed request to make a referral, and I note he states he did not receive any telephoned request. I would expect nursing staff to have continued to try and contact him if the review was felt to be urgent, and they had not heard back from him in a timely manner. Contact was successful on [19 Month10] and [Dr C] made appropriate arrangements for [Mrs A's] transfer.

6. Final comment:
[Dr C] notes, with the benefit of hindsight, he should probably have referred [Mrs A] for surgical debridement of her ulcer on [10 Month10]. However, I feel his management on that day was appropriate, although there were some mild deficiencies in his follow-up of the consultation as discussed above. His general management of [Mrs A] over the course of her admission to EHRV was otherwise consistent with expected standards. I have some doubt whether referral on [10 Month10] would have altered [Mrs A's] management or subsequent clinical course. I think the major factor leading to the delay in appropriate treatment being sought for [Mrs A's] sacral pressure ulcer was a failure by nursing staff to keep [Dr C] adequately informed as to the progress of the ulcer much earlier in its course, and to request his review of the ulcer when it continued to enlarge from [Month7]."