Mercy Parklands Limited

Healthcare Assistant, Ms D

Healthcare Assistant, Ms E

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01093)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report highlights the importance of accurate clinical assessment and recording of individuals' needs in aged residential care facilities, and the importance of all accompanying care plans and supporting documentation being sufficiently clear and comprehensive to guide the provision of care on a day-to-day basis. The report also highlights the importance of aged residential care facilities promoting an "all of staff" culture — across all levels of the organisation — that fosters respect and upholds the dignity of the elderly residents the organisation has been entrusted to protect and care for.

2. The report concerns the care provided to an elderly man at a rest home. During the man's residency there was a lack of accurate assessment and monitoring and, as a result, he lost weight and developed pressure areas, and experienced pain. On 29 April 2018, the man sustained a skin tear to his left ear and a bruise to his right hand during a hoist transfer. There are conflicting accounts from rest home staff about how these injuries occurred. On 22 April 2019, the man's daughter witnessed a healthcare assistant communicating with the man in a loud and aggressive way.

Findings

3. The Deputy Commissioner found Mercy Parklands Limited in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that Mercy Parklands Limited (a) did not complete accurate assessments for mobility and risk of pressure areas, and the care plans were inadequate; (b) did not complete pain assessments or administer pain relief consistently; (c) recorded limited documentation about the concerns raised by the man's family; (d) did not document on a turning chart when the man was turned; (e) did not manage the man's pressure injuries adequately; and (f) did not monitor the man's food and fluid intake adequately. The Deputy Commissioner also found that the rest home did not comply with relevant New Zealand Health and Disability Services Standards and, accordingly, also breached Right 4(2) of the Code.

4. The Deputy Commissioner expressed concern about the allegations made about a healthcare assistant. However, ultimately, the Deputy Commissioner was unable to reconcile the conflicting evidence obtained during the investigation to make a factual finding about what or who caused the man's injuries.

5. The Deputy Commissioner made adverse comment about the healthcare assistant's communication style towards the man on 22 April 2019.

6. Unexplained injuries to vulnerable consumers are particularly troubling, and extremely disturbing when they occur within an aged residential care setting. The ability of the service provider or an independent watchdog such as the Health and Disability Commissioner to investigate such injuries adequately, and substantiate any alleged episodes of elder abuse, is hampered significantly if the injury is sustained by a consumer who is unable to raise the alarm at the time or articulate what has happened to them. In such circumstances, the vulnerable consumer is reliant on others to speak up and advocate on their behalf, and/or for there to be corroborating evidence. Unfortunately, all too often there is insufficient

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information to hand to explain adequately how an injury has been sustained or to reach a finding. The bruising to the man's hand and the skin tear to his ear during a hoist transfer is a case in point.

Recommendations

7. The Deputy Commissioner recommended that Mercy Parklands Limited report back to HDC on its corrective actions; conduct an audit of skin integrity and wound care documentation; and provide a written apology to the man.

8. In accordance with the Deputy Commissioner's recommendation, a healthcare assistant provided a written apology to the man.

9. The Deputy Commissioner recommended that another healthcare assistant provide a written apology to the man.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her father, Mr A, by Mercy Parklands Limited. The following issues were identified for investigation:

- *Whether Mercy Parklands Limited provided Mr A with an appropriate standard of care from 2017 to 2019 (inclusive).*
- *Whether Ms D provided Mr A with an appropriate standard of care in 2018.*
- *Whether Ms E provided Mr A with an appropriate standard of care in 2019.*

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

12. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Ms C	Consumer's daughter
Mercy Parklands Limited	Provider
Ms D	Provider/healthcare assistant
Ms E	Provider/healthcare assistant

13. Further information was received from:

Ms F	Healthcare assistant
Medical centre[1]	

[1] Contracted to provide general practitioner services to the rest home.

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14. Also mentioned in this report:

Dr G	Doctor
RN H	Registered nurse
RN I	Registered nurse
Mr J	Healthcare assistant
RN K	Registered nurse
Ms L	Healthcare assistant

15. Independent expert advice was obtained from Registered Nurse (RN) Rachel Parmee (Appendix A).

Information gathered during investigation

Background

16. On 22 August 2017, Mr A (aged in his eighties) was admitted to hospital-level care at a rest home operated by Mercy Parklands Limited. Mr A had a history of dementia, vascular disease,[2] stroke, left-sided muscle weakness,[3] skin cancer, prostate cancer, and nerve damage.[4] Mr A's wife held an activated enduring power of attorney.[5]

17. This report concerns the care Mr A received from August 2017 until May 2019, in particular the management of his skin integrity, pain, nutrition, pressure areas on his buttocks, and incidents involving healthcare assistants (HCAs)[6] that concern Mr A's safety.

Rest home

18. The facility provides rest-home-level care, hospital-level care, and residential disability services.

Care provided to Mr A from August 2017 until April 2019

August 2017 — admission to rest home

19. At the time of his admission, Mr A weighed 95.5kg, and he was noted to eat a normal diet. He was charted regular medication for pain.[7]

20. On 22 August 2017, a pressure injury care prompt sheet[8] was completed, and Mr A was noted to be independent when moving and repositioning. Also on this date an incontinence

[2] Abnormal condition of the blood vessels.
[3] Left hemiplegia.
[4] Peripheral neuropathy.
[5] A legal document that sets out who can take care of a person's personal or financial matters if that person is unable to.
[6] Also called caregivers or community care workers. They provide assistance, support, and care in residential facilities under the direction of a nurse.
[7] Capsaicin cream, diclofenac (Voltaren), and paracetamol.
[8] A prompt sheet to assess factors involved in maintaining skin integrity.

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assessment was completed, and Mr A was noted to have medium incontinence during the day and incontinence of his bowels and bladder at night.

21. On 23 August 2017, a pressure injury risk assessment[9] was completed to indicate Mr A's risk of developing pressure areas. Mr A was scored as 19 (no risk),[10] but nevertheless he was evaluated as "at risk" of developing pressure areas.

22. A Resident Handling Plan[11] was first completed on 31 August 2017.[12] It documented that Mr A required two-person assistance when using a handling belt and gutter frame for transfers and for walking short distances, and that a wheelchair was to be used when Mr A mobilised for longer distances. The rest home told HDC that a Resident Handling Plan directs staff on the safe handling of residents, and that this does not provide information about a resident's highest level of mobility.

23. On 16 October 2017, the Long Term Care Plan (LTCP) noted that Mr A's family wanted Mr A to increase his mobility by daily walks.

Transfer to long-term care October to December 2017

24. Initially, Mr A was placed in the admissions/short-term area. On 20 October 2017, Mr A was transferred to a long-term area in accordance with the usual practice for new admissions.

Care 2017

25. Mr A's daughter, Ms B, told HDC that following the transfer, her father's regular walks stopped and the gutter frame was used for transfers only, and he became wheelchair bound. Ms B said that he was placed in his wheelchair all day without a break, except for toileting, until he was put to bed at night at around 10pm.

26. The rest home told HDC that Mr A regularly engaged in a balance exercise group from September to November 2017. However, by November 2017, Mr A's mobility had declined and his participation depended on him being alert with verbal and physical prompts, and he was limited to his upper limbs.

27. The Resident Handling Plan was reviewed on 13 November 2017, and, despite the decline in Mr A's mobility, the plan remained unchanged from admission.

28. The pressure injury risk assessment and pressure injury care prompt sheet were reviewed on 31 December 2017, but remained unchanged from admission. The LTCP was updated to reflect the assessments under the section "skin integrity", but no further reviews were recorded in the care plan.

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[9] Using the Braden Scale.

[10] A score of 18 or below indicates a risk of developing pressure areas.

[11] A Resident Handling Plan provides information for healthcare assistants on how to handle residents safely.

[12] Completed by the Safety Handling Co-ordinator and Mobility Therapist.

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2018

29. The Resident Handling Plan was reviewed again on 12 February and 7 May 2018, and it remained unchanged from admission. However, from 10 September 2018, the Resident Handling Plan records that Mr A was using a wheelchair for mobility.

30. In 2018, three further reviews of the pressure injury risk assessment and pressure injury care prompt sheet were completed,[13] and the outcome of the reviews remained unchanged from admission. Mr A was again scored as 19 (no risk) and "at risk" of developing pressure areas, and again it was recorded that he was independent with moving and repositioning.

31. The LTCP was updated on 16 September 2018. The section "Mobility" records that Mr A expressed that he wanted to walk short distances at least once a shift, and that he required a gutter frame and two-person assistance for transfers and walks.

32. The rest home told HDC that Mr A was mobilised by staff as part of his daily routine,[14] and that his mobility fluctuated. The rest home said that between December 2018 and April 2019 there was a gradual decline in Mr A's mobility, and this was attributed to physical changes, including increased sleepiness.

33. Ms B told HDC that from June 2018 her father complained about pain around his buttocks, and that in December 2018 he complained of pain frequently. Ms B said that by December 2018, he was unable to reposition himself in his wheelchair, and she told staff that he was complaining of pain, but there were no interventions or explanations by staff.

Development of pressure injures in 2019

34. On 13 January 2019, the pressure injury risk assessment and pressure injury care prompt sheet were reviewed, and these were largely unchanged from the previous five reviews. There was no review of the pressure injury care prompt sheet in April 2019.

35. On 12 February 2019, Ms B sent an email to a registered nurse raising concerns that her father was complaining about pain frequently, and that he required a mobile chair. A referral was made to the occupational therapist, who reviewed Mr A the following day and provided a mobile chair and a cushion to ease his pain and discomfort.

36. From 13 February to 22 March 2019, the progress notes record that Mr A was comfortable sitting in his chair, and there is no mention of any pain or discomfort.

37. Ms B told HDC that from 18 March 2019 until 4 April 2019, Mr A's family raised concerns with several staff members, including registered nurses and healthcare assistants, that Mr A was in discomfort when sitting and that his buttocks were very sore. Ms B told HDC that staff gave various explanations why Mr A's buttocks were sore, and said that he was given Cavilon spray for pain.

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[13] On 5 March 2018, 22 June 2018, and 16 September 2018.

[14] The resident daily monitoring sheet between September 2017 and November 2018 indicates that on average, staff mobilised Mr A 39.6 times per month.

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Discovery of wound — March 2019

38. On 22 March 2019, RN H documented that "Cavilon spray [was] applied to [the] scratch [on Mr A's] bottom" and that the plan was to keep Mr A comfortable. The rest home stated that when the scratch was discovered, a wound care plan or short-term care plan should have been commenced.[15]

39. From 23 to 27 March 2019, a registered nurse reviewed Mr A daily and recorded that generally he was settled and showed no signs of pain or discomfort, but there is no mention of a review of Mr A's buttocks. The next mention occurred on 28 March 2019, when a nurse recorded in the progress notes: "[B]roken area on bottom right side, scratched, cavilon spray applied … [For assessment of] abrasion of [right] buttock." The plan was to continue to monitor Mr A.

40. The clinical notes on 29 and 30 March 2019 do not record that Mr A's buttocks were reviewed by staff. However, on 30 March 2019 a nurse documented instructions in the progress notes that Mr A was for repositioning every four hours.

41. On 31 March and 1 April 2019, Cavilon spray was applied to Mr A's right buttock, but there is no record that he was repositioned every four hours as directed on 30 March 2019.

42. The clinical notes on 2 April 2019 record that Mr A was settled and showed no signs of discomfort, but no review of his buttocks or repositioning was documented.

43. On 3 April 2019, it was documented that Mr A was settled and sleepy, and showed no signs of discomfort, but it was noted that he was confused and not coherent.

44. The rest home told HDC that on 28 March 2019, staff should have implemented a wound care plan, commenced a Turning Chart, photographed the wound, applied a wound dressing, and a made a referral to the occupational therapist. The rest home stated that repositioning charts were not completed appropriately until this was implemented on 4 April 2019.

Further development of pressure wounds — 4 April 2019

45. On 4 April 2019, Ms B and her sister, Ms C, visited Mr A because of concerns about his complaints of pain on his buttocks.

46. RN H and Mr A's daughters assessed Mr A's buttocks and identified two wounds, one on each buttock. RN H documented: "[W]ound appears stage 2 [pressure injury], both on the inner cheek [buttock], cavilon spray applied." RN H recorded the following interventions: (a) Mr A was positioned on his side; (b) paracetamol was given; (c) a repositioning chart for two-hourly turns was commenced; (d) a referral to an occupational therapist was made; and (e) a GP review was booked for the following day. The "skin integrity" section of the LTCP was evaluated, but there was no mention of a pressure injury — instead, "wound" was recorded in his documentation.

[15] In response to the initial complaint by Mr A's family.

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47. That day, an occupational therapist reviewed Mr A's buttock wounds, as requested. An alternating air mattress was implemented to be used until the pressure injury had resolved, and a two-hourly turning routine was commenced.

48. Ms B told HDC that when her father was asked about the wounds on his buttocks, he said: "It's killing me." Ms B stated that RN H and Ms F were present, and that Mr A was screaming in pain when he was hoisted from his chair to a standing position. Ms B told HDC:

> "[Ms F] took a white face flannel from the basin and proceeded to vigorously rub [Mr A's] bottom which caused him to scream (very loudly) … [Ms F] ignored [Mr A's] pleas and made no attempt to be gentle. She again rubbed the raw skin with the flannel. [Mr A] screamed the same words out again at which point [Ms C] told her to just stop."

49. In contrast, Ms F told HDC that she cleaned Mr A's buttocks with wet wipes following a bowel motion, and it was then that she saw the wounds on his buttocks. She considers that she cleaned his buttocks "carefully and softly". Ms F stated: "[Mr A] reacted by moving ever so slightly when I wiped his [buttocks], indicating he was in pain, but he did not moan or scream."

50. The rest home told HDC that blue flannels are designated for cleaning genital areas, and white flannels are used for anywhere else on a resident's body. The rest home said that at the time of events it may have had issues with its supplier in providing blue flannels for cleaning genital areas.

51. The rest home told HDC that on 4 April 2019, no short-term care plan or wound assessment was completed, and no photograph or measurement of the wound on Mr A's buttocks was taken. The rest home told HDC: "The identification and management of the wound which developed into a pressure area was not managed appropriately."

52. The rest home also said that no pain assessments were completed either before or during the time when the pressure injuries were identified in March and April 2019.

5 April 2019

53. At 5.00pm, Dr G reviewed Mr A's buttocks and recorded in the progress notes:

> "He has developed 2 x areas ulceration inner buttocks with erosion of skin. [Right-hand side] 3cm x 1.5. [Left-hand side] 1cm x 0.75 & 0.5 x 0.5 cm almost coalesced.[16] Looks like [stage two pressure injury[17]] also associated dry lax skin."

54. Dr G made a referral for a wound-care specialist review of Mr A's buttocks, and charted oxycodone as needed for pain relief. The plan was for two-hourly turns, Allevyn and Hypo Fix wound dressings, and Cavilon spray for skin protection.

[16] Grown together.

[17] Partial thickness skin loss with exposed dermis.

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55. On the same day, a photograph of the wounds was taken, a wound care plan was commenced, and wound assessments were recorded. The LTCP was updated and directed staff to dress the wounds, continue with two-hourly turns in bed, and administer pain relief when required.

Further management of pressure injuries

56. By 9 April 2019, the pressure injury on the right-hand buttock had reduced in size from 3cm x 1.5cm to 2.5cm x 1cm, and the injury on the left-hand buttock had reduced from 1cm x 0.75cm x 0.5cm to 1cm x 0.5cm x 0cm.

57. On 9 April 2019, a gerontology nurse specialist reviewed Mr A and recorded: "[Mr A's left buttock] has practically healed now. Looks like a grade [two] or less. [His right buttock] has improved markedly. Now only a grade [one]." On 16 September 2019, the pressure injury care prompt sheet was reviewed, but did not change from the previous review.

58. The rest home told HDC that assessments were largely reviewed within three to six months in accordance with its policy. However, the rest home acknowledged that "these assessments did not accurately reflect [Mr A's] condition", and that the assessment outcomes were not always reflected in the care plans at the time.

59. The rest home told HDC that it does not believe it "failed to provide basic care to [Mr A] over months", which resulted in him developing a pressure injury in April 2019. However, it acknowledged that inadequate communication, documentation, and unsatisfactory clinical care contributed to Mr A experiencing unnecessary pain and discomfort with buttock wounds.

Food and fluid monitoring

60. From 8 to 11 April 2019 a daily food intake chart was completed, but sections of the charts are blank. On 8 April 2019, it was noted that Mr A had juice with his dinner and was very sleepy and dehydrated.

61. The rest home acknowledged that from 8 to 11 April 2019 staff did not complete Mr A's food and fluid charts.

62. On 12 April 2019, Dr G reviewed Mr A and documented that between January and March 2019 his weight loss was 4.3kg. Dr G noted the family's concerns about hydration, and that Mr A was sleepy. Dr G advised staff to commence a fluid input and output chart, take bloods, add a supplement between meals, and administer fluids when Mr A's fluid intake was less than 850ml.

63. A fluid input and output chart showed that from 13–19 April 2019, Mr A's fluid intake remained above 850ml.

Incident on 29 April 2018

64. On 29 April 2018, Mr A was found to have a skin tear on his left ear and a bruise on his right hand. There are conflicting versions of events presented by various staff in relation to this incident.

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Incident form

65. At approximately 11pm on 29 April 2018 it was noted that Mr A had a skin tear on his left ear, and an incident/accident form was completed. HCA Ms D completed the section "describe incident" on the incident/action form signed by RN I. The incident form records that Mr J entered Mr A's room in response to the alarm, and found Mr A on a crash mattress next to his bed. Ms D then entered Mr A's room to assist, and a full sling hoist was used to transfer Mr A back onto the bed, but he was very aggressive. At the time of applying the hoist sling, blood was noted on Mr A's left ear, and the incident form states that Mr A's ear may have been clipped when he fell out of bed or when staff were trying to get him into the sling. Mr A was administered pain relief, and a dressing was applied to the wound on his ear. It was noted that Mr A was "very aggressive and a very strong man".

66. RN I completed the section "actions taken/further information". She recorded that Mr A reported that his ear was caught by the sling, and that Mr A's wife was to be informed of the incident. It is recorded that Mr A's wife was informed about the incident, but the notes do not specify what she was told. In an addendum, it is recorded: "Bruise on right forearm 3.5 x 1.5cm, and R[ight] hand, 3cm x 3cm. Dark purple."

Activation of emergency bell

67. Mr J told the rest home that he attended to Mr A's emergency bell and saw Mr A on the floor, before proceeding to call the emergency bell himself. Mr J said that Ms D arrived to assist.

68. Ms D's account in the incident report is consistent with Mr J's.

69. However, RN K said that Mr J pressed the bell and Ms D went to help. RN K did not mention the first bell. Further, in Ms D's response to the provisional opinion, she submitted that she responded to an alarm bell and found Mr J in the room, but again this mentions only one bell.

Discovery of blood on Mr A's ear

70. Mr J told the rest home that he saw blood on Mr A's ear after he returned from retrieving the hoist (which is consistent with the incident report), and at this time, Ms D was the only person in the room with Mr A. Ms D told HDC that when entering the room after hearing the alarm she saw Mr J in the room and blood on Mr A's sheets, which is inconsistent with what she documented in the incident form. RN K said that Ms D and Mr J both reported a slight tear behind Mr A's ear, and that Mr J said that he did not know what had caused it.

71. Aside from Mr J's account to RN K, it appears to be agreed that Mr A's ear was caught by the sling.

Retrieval of hoist

72. Mr J told the rest home that *he* left to fetch the hoist and Ms D was in the room alone with Mr A at this time. Conversely, Ms D documented in the incident report: "*We* went to get the full hoist."

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Verbal altercation

73. Mr J told the rest home that he heard Mr A saying, "Don't touch me," and that Ms D was also shouting at Mr A. Mr J said that Ms D and Mr A were "shouting at each other". RN K said that she heard noises but they were not fully audible as the door was closed, but she did hear Mr A saying, "Go away, don't touch me." RN K did not say whether she heard Ms D shouting.

Call for assistance

74. Mr J told the rest home that he left the room to call RN K and RN I. However, RN K said that Ms D came to her to report that Mr A was uncooperative and refusing hoist transfer. RN K said that she advised Ms D to stay with Mr A and that she would return shortly to assist with the help of RN I. RN I said that the HCAs reported that Mr A had been unsettled.

75. Ms D told HDC:

> "When I entered [Mr A's] room, another HCA [Mr J] was already present in the room with [Mr A]. What I observed when I entered was [Mr A] on a mattress on the floor. He looked to be in a lot of discomfort. [Mr J] was standing over him while [Mr A] lay there. [Mr J] seemed to be in a panicked state and looked worried. I noticed [Mr A's] blood on the sheets. My immediate reaction was the comfort and safety of [Mr A]. I assisted to transfer [Mr A] to the bed and asked [Mr J] what happened to [Mr A], but he did not answer my question. However, [Mr J] did make a passing comment to me of not to mention anything. I did not think anything of the comment at the time. By the time I finished the transfer, the RN on duty, [RN K], arrived, and so I could leave the room. I then returned to the cares of the others resident I was assisting before."

76. Ms D told HDC that she did not cause the injuries to Mr A's right forearm and right hand. She said that it was her impression that the incident was being handled, because it had happened in Mr J's presence, and she assumed that when RN K arrived to assist, she would have then have completed an incident form.

Investigation

77. The rest home told HDC that on the following day, bruising was noted on Mr A's right hand and lower forearm, and an investigation was commenced. A photograph was taken of the bruising on Mr A's arm, and this was provided to HDC. The photograph shows the bruising described above. As part of its investigation, the rest home obtained statements from the staff involved, and these are set out below.

<u>Mr J's account</u>

78. Mr J recollected that when he re-entered Mr A's room with a hoist, Mr A was angry with Ms D, and they were quarrelling. Mr J said that when he attempted to put the hoist behind Mr A's back, he did not co-operate, and fresh blood was noted behind Mr A's left ear. Mr J stated:

> "[Mr A was] twisting his body and trying to grab [Ms D's] feet … Then I saw [Ms D] use her right foot and pressed it on to [Mr A's] right wrist/lower arm. She was trying to stop

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him moving and he was screaming at her, they had some conflict at this time, shouting at each other for a short while, I heard him saying 'don't touch me'."

RN K's account

79. RN K stated that she saw Ms D enter Mr A's room, and heard Mr A telling the carers several times to "go away, don't touch me". RN K attended and noted that Mr A looked upset and seemed relieved to see her and RN I. RN K said that Ms D reported the skin tear on Mr A's left ear, and told her that it had been noticed by Mr J, but that he did not know how it had been caused. RN K stated that apart from the skin tear on Mr A's left ear, there was no evidence of any injuries or bruises on other areas of Mr A's body that night.

RN I's account

80. RN I reviewed Mr A with RN K and noted blood on Mr A's pyjamas and fingers, and that he was bleeding from his ear. RN I recollected that Mr A reported that his ear had been caught by the sling and that it was sore. RN I stated: "[D]uring that time I didn't see any bruise on his arms."

Outcome of investigation

81. On 4 May 2018, the rest home sent Ms D a letter, which advised that a formal meeting was to be held on 11 May 2018 in relation to the following allegations:

a) "You were quarrelling with a resident under your care. The resident was screaming and saying 'Don't touch me' to you. You were shouting at him."

b) "You pressed your right foot on top of the resident's right wrist/lower arm pressing it down on the mattress, in an attempt to restrain him from moving."

82. During the formal meeting, Ms D denied putting her foot on Mr A's arm. Following the meeting, the rest home sent a letter to Ms D stating that the allegations had been substantiated, and that this amounted to serious misconduct, and her employment was terminated.

83. Ms D told HDC:

> "[The rest home] … dismissed me unexpectedly in April 2018 without any prior warnings given or fairness of trial. I was not a member of the union and because the meeting proceedings were held in haste, I was not given the opportunity to prepare. I was also in shock because of the allegations being made and I didn't know how to respond … I was not given ample opportunity to explain the incident."

84. The rest home told HDC that it followed its process for an investigation, and that it was distraught at the incident and the injury to Mr A, and felt that they informed the family in a sensitive and compassionate manner. In addition, the rest home stated: "[W]e entirely reject [Ms D's] versions of events." The rest home said that the investigation was conducted through a fair and transparent process over 17 days, and that Ms D did not challenge the investigation process or the decision to terminate her employment.

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85. The rest home told HDC that it had provided Ms D with relevant training and support to carry out her position effectively.

86. Mr A's wife stated that at a meeting with the rest home on 23 May 2018, she was told that the bruising on Mr A's arm had been caused by a caregiver stomping on Mr A's hand while he was on the floor, and that the caregiver involved had been dismissed.

87. Ms B told HDC that the rest home did not advise the family that it had commenced an investigation, and did not consult the family about the possible outcomes of the investigation, and did not refer the matter to the Police.

Incident on 22 April 2019 — Ms E

88. Ms B told HDC that at approximately 4pm on 22 April 2019, she entered her father's room and saw Ms E leaning over her father in his wheelchair and yelling at him loudly. Ms B said that Ms E's demeanour was "aggressive, impatient, frustrated and angry". Ms B stated: "I could not understand what [Ms E] was yelling but it had the tone of 'Don't do that! Listen to me! Do what I am telling you!'" Ms B said that she was shocked by the volume of Ms E's voice and her crowding over Mr A, and that Ms L was watching and did nothing. Ms B said that she shouted at Ms E: "What do you think you are doing?"

89. Ms E told HDC that after transferring Mr A to the chair with a standing hoist, she returned and found that he was still holding on to the handle of the hoist. Ms E stated:

> "I told [Mr A] he needed to let go of the hoist (so he and the chair could be separated from the hoist). I was speaking at an audible volume and trying to speak clearly so that [Mr A] could understand what I was asking him to do."

90. Ms E said that the next thing she remembers is Ms B screaming at her. Ms E said that Ms L did not say anything, and then a registered nurse entered the room and asked Ms E to leave. On 23 April 2019, the rest home commenced an investigation into the incident involving Ms E on the previous day.

91. As part of the rest home's investigation, Ms L gave an account, and said that Mr A was very co-operative that day, and Ms E was "telling [Mr A] what to do and what not to do in a heavy voice" that was loud. Ms L recalled that Ms B arrived and yelled at Ms E to stop talking to Mr A and leave the room. Ms L said that Ms E's usual way of communicating was with a heavy voice, and for this reason she did not intervene.

92. On 10 May 2019, a formal disciplinary meeting was held, and subsequently the rest home sent a letter to Ms E advising that the allegation had been substantiated and that the letter was a first written warning in relation to misconduct. A performance improvement plan was commenced for Ms E, and this included education, a reflection on practice, and increased supervision.

93. The rest home told HDC that it provided Ms E with relevant training and support during her employment, and this included an eight-hour orientation day on 24 May 2017, and a course on resident-centred care, which was completed in December 2017.

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94. Ms E told HDC that she was disappointed by the way the rest home investigated this incident, and that Ms B's view was accepted over her view on this matter.

Subsequent events

95. Following a complaint from Mr A's family in April 2019, the rest home conducted an investigation and reported the findings and corrective actions to Mr A's family. In summary, the report stated:

a) There was evidence that the communication between staff and Mr A's family was not at the level required to ensure that Mr A's clinical care and comfort needs were met effectively.

b) The integrated notes and handover notes did not document the concerns raised by Mr A's family adequately, including the condition of Mr A's skin, and care plans were not implemented adequately.

c) The clinical cares were not satisfactory following the discovery of the wound on 28 March 2019.

96. The rest home told HDC that it has implemented additional corrective actions in response to the further concerns raised by Mr A's family during the investigation.[18] In addition, on 2 May 2019 the rest home had a two-hour meeting with Mr A's family and issued written warnings and Performance Improvement Plans, with the three key registered nurses involved in the care of Mr A.

97. In September 2020 a certification audit of the rest home was undertaken by the provider's designated auditing agency. The audit found that there were no areas requiring improvements as a result of this audit.

Further information

98. Ms B told HDC that she hopes that the issues raised in this complaint will be a catalyst for change at the rest home, so that the family can be confident that Mr A will be looked after competently and compassionately.

99. The rest home stated that at the time of events, the healthcare assistants recorded the use of Cavilon cream on the administration chart, while the registered nurses recorded this on Medi-Map.[19] The rest home said that this led to a misunderstanding between the registered nurses and healthcare assistants about documenting the use of creams.

100. The rest home told HDC the following:

a) We have been respectful in how we have engaged with those involved.

b) We have been transparent in the evaluation processes used.

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[18] See paragraph 162.

[19] An electronic system used to manage medication in a facility, including charting, administration, and supply of medication.

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c) We have held our system, ourselves, and others accountable.

d) Individuals have been held appropriately accountable for suboptimal performance.

e) The human and systems fallibility has been acknowledged.

f) We have made system and organisational changes and shared our learnings.

g) We continue to monitor these changes.

h) We continue to work positively with the family.

Relevant policies/procedures

101. The rest home provided HDC with a copy of its relevant policies, and these are summarised in Appendix D.

Responses to provisional opinion

102. Mr A's family, the rest home, Ms D and Ms E were all given the opportunity to respond to the relevant sections of my provisional report. Where appropriate, their comments have been incorporated into the "information gathered" section above. In addition, the following responses were received.

Mr A's family

103. Mr A's family stated: "We are heartened to read that [the rest home] has, belatedly, accepted many of the complaints we made against that company and some of its employees." Mr A's family told HDC that it hopes that the findings and recommendations will serve to improve the care of people like Mr A.

The rest home

104. The rest home refutes Ms B's comment that there was no accompanying change in the assessments and care plan for Mr A. The rest home stated that in 2020, "I" Care plans was implemented and this has emphasised the resident's voice in clinical documentation. The rest home said that in February 2020 it implemented VCare, a new patient management system that ensures that assessment tools are used consistently and accurately to provide appropriate care planning, and that the care and communication is documented accurately. The rest home said that it updates residents' relatives on a weekly basis, and this has increased to daily updates due to COVID-19.

105. The rest home told HDC that it accepts the recommendations in this report. The rest home noted that RN Parmee was satisfied that any recommendations she suggested to the rest home have been implemented, and that the report acknowledges that the rest home has made considerable changes in response to these events.

106. The rest home told HDC that Ms F had no comment to make on the provisional decision.

Ms D

107. Ms D told HDC that she "vehemently denies the Allegations" that she stood on Mr A's arm.

108. Ms D submitted that there is more evidence to find that Mr J injured Mr A before she responded to Mr A's emergency bell, and that he has wrongly blamed her to protect himself.

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Ms D also submitted that Mr J's accurate account of the action that caused the injuries is itself not evidence that someone else inflicted them. Ms D also told HDC that Mr J did not report what he allegedly saw to the registered nurses who immediately responded.

109. Ms D told HDC that these events have caused her stress and hardship and that she has not been able to work since this incident.

Ms E

110. In response to the provisional opinion, Ms E told HDC that she accepts that she was verbally directing Mr A as she moved him into his wheelchair with a hoist when Ms B entered the room, and shouted at her, accusing her of yelling at Mr A. Ms E disputes the allegation that she yelled at Mr A. She submitted against the proposed adverse comments because they do not give adequate consideration to her account of these events and relied excessively on Ms L's account.

111. Ms E submitted:

> "I now work nights which means I am able to use a lower and quieter voice. I also try to explain to residents' families that English is my second language and that sometimes I need to speak more audibly so I know [I] can be understood. Most family members understand this and appreciate the explanation. In all cases though I try to lower my voice and not speak so loudly."

112. Ms E told HDC that since these events, she has completed the New Zealand Certificate in Health and Wellbeing (Advanced Support) Level Four, and that this training includes extensive work on communication.

Opinion: Mercy Parklands Limited — breach

Introduction

113. Mercy Parklands Limited had a duty to provide services to Mr A with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate reasonable care. Mercy Parklands Limited also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

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

114. Mr A transferred to the rest home for hospital-level care in August 2017. I have a number of concerns about the care provided to Mr A from August 2017 until April 2019 relating to the overall care and management of his skin integrity, nutrition, and pain. Mr A developed pressure injuries and weight loss that likely would have been preventable had the appropriate measures been implemented in a timely manner. Mr A, not least on account of

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his comorbidities and general state of health, would have benefited from having a comprehensive care plan in place that was regularly reviewed and amended in response to any change in Mr A's presenting symptoms. This would have helped to ensure his cares were consistently delivered by all staff.

115. In addition, serious incidents involving the care of Mr A by support staff compromised the safety and empathy of the care provided. These were distressing events for Mr A and his family. I note that aspects of the failings identified in the incidents have been attributed to the individual providers involved, and that the rest home took actions to investigate the incidents.

116. However, in my view there were deficiencies in the care provided to Mr A by multiple staff at the rest home, and these were systemic issues for which the rest home bears responsibility. These are outlined below.

Pressure area assessment, management, and wound care

117. My expert advisor, RN Rachel Parmee, advised that Mr A was at high risk for developing pressure areas when he became wheelchair bound, owing to his history of stroke, dementia, and incontinence.

118. RN Parmee advised that the initial assessment of Mr A's mobility and the assessments for pressure areas were inaccurate, and there were omissions and inaccuracies in the documentation of the care provided.

119. By November 2017, Mr A's mobility had declined significantly, but his Resident Handling Plan, pressure injury risk assessment, and pressure injury care prompt sheet assessments remained largely unchanged from admission. The pressure injury risk assessment scored Mr A as 19 (no risk) of developing pressure areas, and indicated that he was independent with moving and repositioning. However, this is contrary to Mr A's family's account that by December 2018 Mr A was unable to reposition himself in a wheelchair. Mr A's long-term care plan should have been informed by the above assessments, but this occurred only once on 31 December 2017. By this time Mr A had been transferred to a long-term area in accordance with the usual practice for new admissions, where staff should have been prepared for managing hospital-level residents long term.

120. RN Parmee advised that had accurate assessment, planning, and preventative interventions (such as repositioning and pressure-relieving equipment) been implemented, it is reasonable to expect that Mr A's skin deterioration would not have occurred. RN Parmee considers that this represents a severe departure from accepted practice.

121. I agree with RN Parmee, and I note that the rest home acknowledges that the assessments were inaccurate and not reflected consistently in the care plans. Mr A was at a high risk of developing pressure areas, but was not assessed and monitored adequately, and the lack of a plan for his skin integrity and mobility meant that he did not receive the appropriate interventions in a timely manner. It is essential that care plans are supported by accurate assessments, and I am critical of the rest home that this did not occur, and that Mr A developed pressure injuries.

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Management of pressure areas

122. On 22 March 2019, a scratch on Mr A's buttocks was discovered, and by 28 March 2019 the scratch had developed into an abrasion. There is no evidence in the clinical notes that staff reviewed Mr A's buttocks or implemented any nursing interventions until 30 March 2019, when instructions for four-hourly turns were documented.

123. RN Parmee advised that a Turning Chart should have been commenced on 30 March 2019, and Mr A's care plan should have reflected this instruction. However, no turns were recorded from 30 March to 3 April 2019, and the first recorded turns commenced on 4 April 2019, when the Turning Chart was initiated. RN Parmee was critical that there is no documentation to indicate that Mr A was repositioned until 4 April 2019, and this represents a moderate departure from the accepted standards.

124. On 4 April 2019, a nurse noted a stage 2 pressure injury on Mr A's buttocks, and nursing interventions were implemented. However, no photograph or measurement of Mr A's buttock wound was taken as per usual practice for wound management, and a wound care plan was not commenced until the following day. RN Parmee was mildly critical of the omission to photograph the wound, as a photograph was taken later by the wound care specialist.

125. Overall, RN Parmee considers that the care provided to Mr A in regard to the development of pressure areas on his buttocks represents a severe departure from the accepted standards of care.

126. The rest home acknowledged that the appropriate wound care interventions were not commenced on 22 and 28 March 2019 when this was warranted, and that the repositioning charts were not completed appropriately until 4 April 2019.

127. I accept RN Parmee's advice. I am concerned that the clinical notes indicate that Mr A was not turned for a number of days. Had a Turning Chart commenced on 30 March 2019, when this was warranted, staff would have been clear about Mr A's turning regimen. I am critical that the lack of documentation meant that measures to relieve pressure injuries were not communicated to staff. I am also critical of the lack of review of Mr A's deteriorating skin, and that consequently he did not receive the appropriate interventions in a timely manner.

Pain

128. Mr A complained to his family about pain around his buttocks from June 2018 to April 2019. On several occasions Mr A's family alerted staff that Mr A had been complaining about pain frequently, but this was not documented in the progress notes consistently.

129. The progress notes show that following the discovery of an abrasion on Mr A's buttocks on 22 March, Cavilon spray was applied intermittently for pain until 5 April 2019.

130. The rest home stated that there was misunderstanding between nurses and healthcare assistants about recording medication, owing to a transition in its medication management system. The rest home acknowledged that no pain assessments were completed for Mr A either before or during the time his pressure injuries were discovered.

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131. Mr A's pain was not documented consistently, and available treatment including Cavilon spray was not used consistently or documented. Mr A articulated clearly that he was in pain, and RN Parmee advised that his expression of pain could have been recorded using a tool such as the Abbey Pain Scale.

132. I am critical that the registered nurses did not monitor Mr A's pain adequately or use a pain assessment tool to assess the effectiveness of the pain relief provided, given the repeated concerns raised by both Mr A and his family. I am concerned that there was a lack of clarity about documenting medication, and omissions in documentation of the pain relief used. Mr A's family raised multiple complaints to staff about his pain, and the failure to document the communication with family meant that opportunities to manage his pain and provide timely interventions was not actioned. It is reasonable to assume Mr A was subject to unnecessary and avoidable distress as a result.

Ms F, 4 April 2019

133. Mr A's daughter told HDC that Ms F rubbed Mr A's buttocks vigorously with a white flannel, which caused him to scream, but she ignored his plea to stop, made no attempt to be gentle, and again rubbed the raw skin with the flannel.

134. In contrast, Ms F recollected that she cleaned Mr A's buttocks with wet wipes following a bowel motion, and discovered the wound on his buttocks. She said that she cleaned his buttock "carefully and softly", and that Mr A "reacted by moving ever so slightly when I wiped his [buttock], indicating he was in pain, but he did not moan or scream".

135. On the evidence before me I am open to the possibility that the use of a flannel on Mr A's existing wound would have created discomfort to Mr A, although I am unable to determine to what degree, and it is possible that some pain (irrespective of the administration of pain relief) may have been unavoidable if the wound was particularly sensitive. However, irrespective of the exact nature of events, this complaint highlights the importance of staff providing safe and empathetic care to vulnerable residents. I note that the rest home has provided education to healthcare assistants on providing safe and empathetic care, and I consider this appropriate.

Food and fluid

136. RN Parmee advised that given Mr A's level of dementia and inability to care for himself in terms of accessing food and fluids, staff should have been alert to the need to monitor his nutritional status.

137. From 8 April to 11 April 2019, food and fluid charts were not completed adequately. On 12 April 2019, Mr A's weight loss was recorded as 4.3kg (between January and March 2019), a significant loss over a short period of time. Mr A's family also raised concerns with the GP about his hydration,

138. RN Parmee advised that Mr A's food and fluid intake should have been monitored and recorded daily, and his hydration and nutrition needs assessed to indicate where intervention was required. RN Parmee advised that the "monitoring of [Mr A's] weight

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trends should have alerted RNs to seek advice from a dietitian and the introduction of supplements … in line with the supplied nutritional assessment in elderly policy".

139. RN Parmee also advised that the food and fluid charts completed prior to 12 April 2019 were incomplete and inadequate, and considers that in view of Mr A's weight loss of 4.3kg, this represents a severe departure from accepted standards.

140. I agree with this advice. I am critical that staff did not monitor and document Mr A's food and fluid intake adequately when this was warranted, in light of his vulnerabilities. As a result, there was a delay in recognising Mr A's weight loss and hydration issues. Had staff assessed Mr A for his hydration and nutritional needs, this may have alerted them to refer Mr A for specialist advice, which was warranted. I am critical that staff did not comply with the nutritional assessment policy.

Conclusion

141. In my view, the rest home had the ultimate responsibility to ensure that Mr A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). RN Parmee stated:

> "There were serious departures in the standard of care provided to [Mr A] prior to the discovery of his pressure injuries. There were clear lapses in terms of accurate assessment and care planning which led to the unacceptable consequences of pressure injuries, weight loss and possible dehydration. Preventative measures were not implemented in a timely manner."

142. I agree, and conclude that there were deficiencies in the care provided to Mr A for the following reasons:

- The assessments for mobility and risk of pressure areas were inaccurate, and the care plans failed to guide staff to provide the appropriate interventions.
- Pain assessments were not completed, and staff did not document consistently when pain relief was given.
- Staff failed to document the concerns raised by Mr A's family that he was experiencing pain and discomfort.
- There is no documentation that Mr A was turned every four hours, as directed on 30 March 2019, and the instructions were not documented on a turning chart.
- Staff did not initiate the appropriate wound care interventions and monitoring on 22 March, 28 March, and 4 April 2019 when Mr A's skin deterioration was noted.
- The monitoring of Mr A's food and fluid intake was inadequate, charts were incomplete, his weight loss was 4.3kg, and a referral to a specialist for advice was indicated, but did not occur.

143. In light of the issues identified above, I consider that the care provided to Mr A by the rest home was inadequate and resulted in Mr A developing pressure injuries and weight loss

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when these may have been preventable. Accordingly, I find that the rest home did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.[20] These failures meant that Mercy Parklands Limited did not comply with the NZHDSS and, consequently, Mercy Parklands Limited also breached Right 4(2) of the Code.[21]

Respect and dignity — other comment

144. Mr A's family reported three serious incidents involving the care of Mr A by support staff. These include allegedly wiping Mr A's buttocks with a flannel and causing him discomfort, and yelling at and injuring Mr A. The staff involved deny the events as alleged by Mr A's family, and have provided alternative accounts and explanations for their actions.

145. This case highlights the challenges faced when trying to determine with sufficient certainty how or what potential harm has occurred for a vulnerable consumer. Where potential episodes of harm or elder abuse have occurred, I am cognisant that there are times where there is no ability to determine how an injury has been sustained. When there are witnesses, in the absence of any other evidence, we are reliant on the honest accounts of the individuals who observed the incident. In circumstances where there are several witnesses and conflicting versions of events are presented it becomes extremely challenging to reach a definitive conclusion. I am mindful too that the voice of the consumer is often not present in this type of situation and we are left unable to know, from their perspective, what has happened and how they were impacted. Accordingly, there is a collective responsibility to ensure there are layers of protection in place for our frail elderly consumers residing in aged residential care facilities. The safeguards encompass many elements, including, for example, the organisation's staff recruitment strategy, its training and staff development programme, its policies and procedures, and, perhaps most significantly, the culture of the organisation and its focus on upholding the rights of its consumers.

146. I remind the rest home of its responsibility to foster a culture among staff that respects the dignity of its residents. I note that the rest home has provided education to healthcare assistants on providing safe and empathetic care, and I consider this appropriate.

Opinion: Ms D — adverse comment

147. On 29 April 2018, Ms D attended to Mr A following a fall from his bed. Ms D and another healthcare assistant, Mr J, transferred Mr A back to bed using a sling hoist. During the transfer, Mr A's left ear was caught in the sling. Ms D recorded in the incident/accident form that Mr A was "very aggressive and very strong", and that the skin tear on his ear was caused by either the fall from his bed or when the sling hoist was applied.

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

[21] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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148. Mr A also sustained a bruise to his right hand. It has been alleged that Ms D caused this injury by pressing her foot on Mr A's wrist. Ms D strongly disputes this.

149. RN Parmee advised that if Ms D used unnecessary physical restraint by placing her foot on Mr A's arm while attempting to apply a hoist sling, this would represent a severe departure from accepted practice.

150. As outlined in paragraphs 63–79, there are significant factual discrepancies surrounding this incident. Where there is conflicting evidence, the standard applied when preferring certain evidence is the balance of probabilities. This standard is applied flexibly. That is, the more serious the allegation, the stronger the evidence required to establish the events that occurred.[22]

151. Having carefully considered the information before me, I am unable to reconcile the inconsistent accounts from staff at the rest home. Specifically, I note the only two people present in the room with Mr A when his arm was injured have presented conflicting evidence to this Office. In the absence of any other evidence that may support one version over the other, and given that I am considering a very serious allegation of physical assault, I am unable to make a factual finding, on the balance of probabilities, about what or who caused the injuries to Mr A's arm.

152. I acknowledge the investigation conducted by the rest home and its subsequent outcome. However, my investigation has been conducted independently of this, and for the reasons set out above, I am unable to reach the same factual conclusions as the rest home internal investigation.

153. In any event, Mr A was a vulnerable consumer with dementia who was dependant on the care provided by staff. Although I have not been able to reach a factual conclusion about what exactly occurred to cause Mr A's injuries, I am fully cognisant of the distress that Mr A was in at the time of these events, and the effect that this will have had on him and his family. I cannot stress how very concerned I am by the allegations made against Ms D, and I would be very critical if Ms D had engaged in any form of physical restraint of Mr A and contributed to Mr A's injuries in any way.

Opinion: Ms E — adverse comment

154. On 22 April 2019, Mr A's daughter, Ms B, told HDC that she entered her father's room and saw Ms E leaning over her father in his wheelchair and yelling at him loudly. Ms B said that Ms E's demeanour was "aggressive, impatient, frustrated and angry". Ms B said that although she could not understand Ms E, the tone of yelling was "Don't do that! Listen to me! Do what I am telling you!". Ms B said that she was shocked by the volume of Ms E's

[22] *Z v Complaints Assessment Committee [208] NZSC 55.*

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voice and her crowding over Mr A. Ms B said that she shouted at Ms E: "What do you think you are doing?"

155. In contrast, Ms E said that she was speaking at an audible volume and trying to speak clearly so that Mr A could understand her instructions.

156. A healthcare assistant who witnessed the events stated that Ms E told Mr A what to do and what not to do in a heavy voice that was loud, but that Ms E usually communicated with a heavy voice, and for this reason she did not intervene. My expert advisor, RN Rachel Parmee, advised that the standard of practice is that healthcare assistants use communication techniques that are positive and reflect an attitude of empathy and caring. RN Parmee stated that it is particularly important that these skills are utilised in the care of a resident with dementia, and that carers understand the disease process and its effects on behaviour.

157. I agree. I acknowledge that Ms E considered that she was using her normal voice, and said that because English is her second language, she needed to speak clearly and audibly in order to be understood, and she was giving clear instructions to transfer Mr A into his chair safely. However, this needs to be balanced with the importance of residents being entitled to be treated with respect and dignity, particularly elderly, vulnerable consumers who cannot advocate for themselves.

158. In light of Ms B's evidence and Ms L's account, I accept that Ms E's communication style could be construed as yelling. From what Ms B recalled, including the way she responded to Ms E, it was Ms B's experience that her father was being yelled and, understandably, this would have been distressing.

159. I do not consider that Ms E's communication was positive or reflected an attitude of empathy or caring for vulnerable consumers. I am concerned that Ms E's usual communication with residents is in a manner that could be construed as yelling. This is a concerning trend that warrants closer attention. In my view, Ms E needs to be supported to develop appropriate communication strategies to work with vulnerable consumers who may be intimidated by her communication.

160. I note that since these events, Ms E has had increased supervision and education, and I consider this appropriate.

Changes made since events

Ms E

161. Ms E stated that she has reflected on this incident and has tried to make some changes to her practice. She now tries to use a lower voice and not speak so loudly in her practice. Ms E told HDC that since these events, she has completed the New Zealand Certificate in Health and Wellbeing (Advanced Support) Level Four, and that this training includes extensive work on communication.

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The rest home

162. The rest home told HDC that since these events, it has made changes and improvements in the following areas:

a) Assessments: Nursing assessments, including pain and skin assessments, are completed on admission and reviewed every three months.

b) Acute concerns are incorporated into relevant assessments, with goals and time frames incorporated in short-term care plans for reference.

c) Care plans:

   i. Long-term care plans are reviewed every three months, and short-term care plans are commenced for acute issues.
   ii. Education on care planning has been provided to staff.

d) Organisation: Review of the Code of Conduct and development of a person-centred model of care.

e) Pain management:

   i. Pain assessments are completed on admission, and reviewed every three months.
   ii. Pain assessment is used together with the short-term care plan when there is an acute issue around pain.
   iii. A pain scale is part of the pain assessment, and is reflected in Medi-Map when PRN (as necessary) medication is administered.
   iv. The rest home uses the verbal and non-verbal pain assessments Visual Analogue Scale and Abbey Pain Scale.

f) Pressure injury prevention:

   i. Education is provided to staff on pressure injury prevention and management and repositioning.
   ii. Skin assessments are completed on admission and reviewed every three months.
   iii. The repositioning chart has been updated and audited.
   iv. Pressure injury information is completed on admission.
   v. Any incidents/accidents are logged for follow-up by the registered nurses on duty.
   vi. All wounds are reported as an incident and measured, and photographs are taken at every review.
   vii. Registered nurses complete wound care education within six weeks of their employment.
   viii. ISBAR[23] documentation is used to refer to GPs and specialists.
   ix. All stage 3, 4, unstageable, and chronic wounds are referred to a wound specialist.
   x. The food and fluid intake chart has been updated.
   xi. Pressure injury management includes discussion with family about a referral to a dietician.

[23] A standardised approach to communication. ISBAR stands for Introduction, Situation, Background, Assessment, Recommendation.

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xii. Education on the use of Cavilon spray and dimethicone cream is provided to registered nurses.

g) Clinical care/nursing:

i. Short-term care plans are commenced for all acute issues, and these are logged to ensure identification and evaluation for acute issues.
ii. Education on care planning is provided to registered nurses.
iii. The rest home has transitioned from the use of a paper-based medication management system to Medi-Map.

h) Human resources:

i. Recruitment processes have been reviewed, including reference checks and the interview process.
ii. The orientation and induction process for new healthcare assistants has been reviewed.

Recommendations

163. I acknowledge the considerable changes made by the rest home in response to these events. I note also that the subsequent certification audit of the rest home undertaken in September 2020 concluded that all standards applicable to the service were fully attained. This would suggest that the rest home has addressed the deficiencies in service that have been identified.

164. I recommend that Mercy Parklands Limited:

a) Provide an apology to Mr A for its breaches of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.
b) Provide to HDC, within three months of the date of this report, an update on the corrective actions taken arising from this complaint.
c) Conduct a random audit of skin integrity and wound care documentation for ten residents over the past six months, to ensure compliance with the relevant rest home policies. The rest home is to report the results of the audit to HDC within six months of the date of this report. Where the audit results do not show 100% compliance, the rest home is to advise what further steps will be taken to address the issue, and undertake a further audit to confirm compliance.

165. In accordance with my recommendation, Ms D provided a written apology to Mr A, and this has been forwarded.

166. I recommend that Ms E provide a written apology to Mr A, to be sent to HDC within three weeks of the date of this report, for forwarding.

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Follow-up actions

167. A copy of this report with details identifying the parties removed, except Mercy Parklands Limited and the expert who advised on this case, will be sent to HealthCERT (Ministry of Health), the district health board, Te Whatu Ora — Health NZ, the Māori Health Authority, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes. They will be invited to consider the adequacy of the current safeguards for protecting vulnerable consumers.

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Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"Thank you for the request to provide clinical advice regarding the care provided by [the rest home] to [Mr A] [from 2017 until] March 2019. In preparing the advice on this case, to the best of my knowledge, I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

1. I registered as a nurse in 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is coordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

2. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr A] by [the rest home] was reasonable in the circumstances and why.

With comment on:

1. Whether the care provided to [Mr A] was adequate and consistent with relevant nursing standards
2. Whether the care [Mr A] received for his skin deterioration was appropriate, timely, and consistent with relevant standards
3. The adequacy of [Mr A's] food and fluid monitoring
4. The alleged assault by a caregiver, and the subsequent management of this incident by [the rest home]
5. Any other matters that I consider warrant comment.

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For each question I am asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.
c. How would it be viewed by my peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

3. In preparing this report I have reviewed the documentation on file:

    1. Letter of complaint dated 17 June 2019

    2. [The rest home's] full response dated 16 August 2019, including Appendices 1–23

4. Background

[Mr A] has been cared for by [the rest home] since 22 August 2017. [Mr A] has dementia with lewy body features, hallucinations and delusions. He is wheelchair bound. [Mr A's] two daughters have made a complaint to the HDC office with concerns about [Mr A's] skin health since being under [the rest home's] care as well as an alleged assault.

5. Review of Documents

6. Whether the care provided to [Mr A] was adequate and consistent with relevant nursing standards

In her letter of complaint [Ms B] raises concerns about the care provided to her father in relation to the development and management of pressure areas on his buttocks. Her concerns relate to communication, documentation and management of clinical care and comfort in relation to [Mr A's] skin integrity.

[The rest home] provided a response to [Ms B's] initial complaint to the facility and again to the Health and Disability Commissioner. In these responses the representatives of [the rest home] ([the] Operations Manager and [the CEO]) substantiate the allegations related to communication, inadequate documentation and unsatisfactory clinical care.

I will discuss the classification of [Mr A's] buttock wound and food and fluid monitoring below.

a. What is the standard of care/accepted practice?

The relevant nursing standards in this case pertain to assessment, planning, implementation and documentation of care.

[Mr A's] mobility changed significantly on transfer [to long-term care] at [the rest home]. In [long-term care] he became wheelchair bound and no longer walked with a gutter frame as he had [on admission]. This change in mobility and subsequent long periods in a wheelchair, along with a history of CVA significantly increased the risk of pressure areas developing.

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As [Ms B] points out there was no accompanying change in the assessments and careplan for [Mr A]. For example, the Safe Handling Policy form completed by the Mobility Therapist was inaccurate for three iterations. The long-term Care plan which was completed in September 2018 stipulated walking short distances at least once per shift. There is no documentation stating that this occurred and as [Ms B] points out is not consistent with the development of [Mr A's] pain and pressure areas. There appears to have been inaccurate documentation on the Resident Daily monitoring Form — Pressure Risk Alert. There was also inaccurate documentation on the Braden scale and Pressure Injury Care — Prompt Sheet indicating that [Mr A] was low risk for pressure areas and able to change position independently.

In summary there were clearly shortfalls in the initial assessment of [Mr A's] mobility and pressure area risk. Inaccurate assessment leads naturally to inaccurate care planning. On top of this there were omissions and inaccuracies in the documentation of [Mr A's] care.

[Mr A's] pain was not documented consistently, and available treatment appears not to have been used (e.g. Cavilon spray) or documented. The assertion allegedly made by [Dr G] that people with cognitive impairment can't express pain is inaccurate. [Mr A] clearly articulated that he was in pain and his expression of pain could easily have been recorded using a tool such as the Abbey pain scale.

b. If there has been a departure from the standard of care or accepted practice, and how significant departure this is?

There was a severe departure from the expected standard of care. This is evident in the level of pain [Mr A] was in and the development of a pressure area on his buttocks.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

Recommendations include ensuring that assessment tools are used consistently and accurately and that these tools are used to provide appropriate care planning. Care provided and communication with relatives and other health professionals needs to be clearly, consistently and accurately documented.

7. Whether the care [Mr A] received for his skin deterioration was appropriate, timely, and consistent with relevant standards

As discussed above the inadequate care [Mr A] received, particularly in relation to his immobility and inability to change his position while sitting for long periods in a wheelchair and later in a mobile armchair, contributed to the deterioration in the skin on his buttocks. If accurate assessment, planning and preventative interventions had taken place it is reasonable to expect that the skin deterioration would not have

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occurred. I am satisfied that appropriate interventions were put in place upon discovery of the broken skin and understand that the pressure area healed well subsequently.

There is debate about the aetiology and stage of the break in [Mr A's] skin and the completion of notification to the Ministry of Health. In my opinion the major concern is that there was a break in the skin which was preventable and that there was insufficient monitoring of [Mr A's] skin prior to the discovery of the break by his daughter [Ms C].

a. What is the standard of care/accepted practice?

Accepted practice is that a person with a high risk for pressure areas is assessed and monitored regularly with appropriate preventive measures in place.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.

There was a severe departure from the expected standard of care. [Mr A] is clearly at high risk for the development of pressure areas with his immobility, history of CVA, incontinence and dementia. The risk factors for a pressure area were not noted or acted upon in a timely manner. This is unacceptable as the pressure area was predictable and preventable with appropriate monitoring and care in place.

[Dr G's] notes of 12th April include a list of interventions including:

Daily picture of wound

4 hourly turns in bed

Only sitting for 2 hours at a time

Sit up for drinking.

I would expect each of these interventions to have been in place and that a Registered Nurse would have included these in a care plan based on their own assessment rather than the GP having to ask for these after the discovery of a pressure area.

c. How would it be viewed by my peers?

My peers in education and practice would agree that the situation was preventable and predictable.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

My recommendations are that assessment tools are used accurately, and that care is planned, implemented and documented to provide consistent monitoring and prevention of pressure areas.

While the pressure areas should not have occurred, I am satisfied that [the rest home] has responded swiftly and appropriately in ensuring that a similar occurrence will not happen in future.

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8. The adequacy of [Mr A's] food and fluid monitoring
Given [Mr A's] level of dementia and inability to care for himself in terms of accessing food and fluids it is reasonable to expect that his food and fluid intake be monitored and recorded in his daily progress notes or on a chart.

In their response [the rest home] state[s] that following [Dr G's] review of [Mr A] on 12 April 2019 and in response to the family's concerns about dehydration the following actions were implemented: recording of fluid input and output, blood testing, addition of Cubitan supplement and an order for sub-cut fluids if intake less than 850 mL.

The food and fluid charts included in [Ms B's] complaint were completed prior to this date and were incomplete and inadequate. The charts supplied by [the rest home] following the 12th of April were comprehensive and generally well completed. This documentation indicates that [Mr A's] food and fluid intake was monitored, and his fluid intake remained above 850mL per day.

a. What is the standard of care/accepted practice?

The standard of care is that residents are assessed for hydration and nutrition needs. Regular nutrition assessment and monitoring of monthly weight records by registered nurses is used to indicate where intervention is needed in terms of dietary supplementation and monitoring of intake. It is expected that a dietitian assessment takes place if there is continued weight loss. Nurses are expected to be able to assess for dehydration and take appropriate steps to prevent dehydration such as monitoring of fluid intake.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.

Prior to [Dr G's] consultation on 12th April there appears to have been a severe departure from accepted practice. [Dr G] notes a weight loss of 4.3 kg between January and March in her entry on 12th April. Monitoring of [Mr A's] weight trends should have alerted RNs to seek advice from a dietitian and the introduction of supplements. This is in line with the supplied Nutritional Assessment in Elderly policy.

c. How would it be viewed by my peers?

My peers in education and practice would agree.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Assessment of nutrition and hydration needs to occur with the use of accurate documentation and interventions based on this information.

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9. The alleged assault by a caregiver, and the subsequent management of this incident by [the rest home]

The documentation provided by [the rest home] includes an Incident report, a photo of [Mr A's] injury, statements by the HCA and RNs involved, letter from [the rest home] advising HCA of allegations, letter of termination.

a. What is the standard of care/accepted practice?

The accepted standard of practice is that incidents where serious misconduct is suspected are investigated by senior management through a process which is transparent and clearly documented. This is in line with the supplied Code of Conduct: House Rules and Disciplinary Action Process.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.

I do not believe there was a departure from expected practice. The information provided shows that the incident was documented and investigated in a fair and appropriate manner.

c. How would it be viewed by my peers?

My peers would agree.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

None.

Conclusion

There were serious departures in the standard of care provided to [Mr A] prior to the discovery of his pressure injuries. There were clear lapses in terms of accurate assessment and care planning which led to the unacceptable consequences of pressure injuries, weight loss and possible dehydration. Preventative measures were not implemented in a timely manner and I am concerned that basic nursing care needed to be prescribed by the GP.

However the responses from [the rest home] indicate that they took the complaints very seriously, conducted a thorough investigation and found that allegations of inadequate communication, inadequate documentation and unsatisfactory clinical cares were substantiated. A fourth allegation that the wound on [Mr A's] buttock was a Stage 3 pressure injury and that [the rest home] had not fulfilled its Section 31 reporting obligation was not substantiated.

[The rest home] has provided evidence of corrective actions taken including a disciplinary process with RNs involved, workshop education in relation to communication, documentation, and care plan policies and procedures, skin integrity

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education including pressure injury prevention and management, HCA education on handover, documentation and maintenance of skin integrity.

I also note that a report was filed with HealthCERT in relation to [Mr A's] pressure injuries.

I am satisfied that any recommendations that I would suggest have been implemented at [the rest home].

Rachel Parmee
RGON, MA (Nursing)"

The following further advice was received from RN Parmee on 3 April 2020:

"Thank you for the opportunity to provide further advice on this case for which I provided initial advice on 24th November 2019.

I am asked to advise on the following:

1. In relation to the alleged physical abuse by a health care assistant (HCA) on 29 April 2018, whether the actions of the HCA during the incident itself were adequate/appropriate.
2. On 4 April 2019, [Mr A's] family visited him at [the rest home] and they first sighted his pressure injuries. They recalled a caregiver vigorously rubbing his buttocks with a flannel and [Mr A's] daughter had to intervene. [The rest home] also told HDC that the RN present did not take a photo of the wound and measure it, as per usual practice.
   a) Whether the RN's assessment was adequate/appropriate
   b) Whether the caregiver's action of vigorously rubbing the pressure injuries with a flannel was adequate/appropriate.
3. On 9 April 2019, a gerontology nurse specialist from [the public hospital] assessed [Mr A's] pressure injuries, with assistance from two [rest home] RNs.
   a) Whether the assessment by the gerontology nurse specialist was adequate/ appropriate
   b) Whether the actions of the [rest home] RNs during the assessment, including if they assisted wearing gloves, were adequate/appropriate.
4. On 22 April 2019, [Mr A's] family member arrived to find a HCA leaning over [Mr A] seated in his wheelchair, yelling at him loudly.
   a) Whether the HCA's actions were adequate/appropriate
   b) Whether [the rest home's] actions following this incident were appropriate.
5. On 30 March 2019, there was an RN instruction in [Mr A's] progress notes to reposition him every four hours.

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a) Whether the repositioning was adequate following the above instructions.

6. [The rest home] conducted an internal investigation and provided its report to [Mr A's] family in April 2019.
   a) Whether the actions taken by [the rest home] in relation to the internal investigation were adequate/appropriate.

7. In relation to the above and previous advice, whether I consider any of the departures from the standard of care or accepted practice to be attributable to individuals and if so to identify these individuals.

For each question I am asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)?
c. How it would be viewed by my peers
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Review of Documents

1. **In relation to the alleged physical abuse by a health care assistant (HCA) on 29 April 2018, whether the actions of the HCA during the incident itself were adequate/ appropriate.**

In my initial report I was asked to comment on the alleged assault by a caregiver, and the subsequent management of this incident by [the rest home]. My comment was that there was no departure from expected practice as the incident was documented and investigated in a fair and appropriate manner following the supplied Code of Conduct, House Rules and Disciplinary Action process.

I am now asked to comment on the actions of the health care assistant during the incident. Clearly the actions of [Ms D] were inappropriate as evidenced by the statements of [RN I], [RN K] and [Mr J]. It appears that the HCA used unnecessary physical restraint by placing her foot on [Mr A's] arm while attempting to apply a hoist sling. The bruising on [Mr A's] arm was consistent with these accounts.

As I stated in my initial report the incident was investigated and it was found that the HCA's actions amounted to serious misconduct and she was dismissed immediately.

In summary the actions of the HCA were inappropriate and appropriate action was taken in terms of investigation and subsequent dismissal of the HCA.

I still maintain that in terms of the response to this incident there was no departure from accepted practice. In terms of the incident itself there was a severe breach of accepted practice which was addressed appropriately by [the rest home].

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2. On 4 April 2019, [Mr A's] family visited him at [the rest home] and they first sighted his pressure injuries. They recalled a caregiver vigorously rubbing his buttocks with a flannel and [Mr A's] daughter had to intervene. [The rest home] also told HDC that the RN present did not take a photo of the wound and measure it, as per usual practice.

a. Whether the RN's assessment was adequate/appropriate.

The wound assessments provided in Appendix 8 have been completed appropriately. However, there are no photographs uploaded into the space labelled 'photo'.

b. What is the standard of care/accepted practice?

Accepted practice is that wounds are assessed using a standard wound assessment tool which contributes to the development of a short term careplan. It is best practice that photographs are used as part of the assessment process.

c. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)?

I believe the departure to be mild given that all other assessment criteria were used and that photographs were taken after the assessment by the wound care specialist.

d. How it would be viewed by my peers?

I believe my peers would agree.

e. Recommendations for improvement that may help to prevent a similar occurrence in future.

That photographs be implemented as a regular element of the wound assessment process and all sections (including photographs) be completed on the assessment form.

b) Whether the caregiver's action of vigorously rubbing the pressure injuries with a flannel was adequate/appropriate.

In her response to HDC [the CEO] discusses the use of flannels and soap and water in cleaning genital areas. Along with the rationale for using different coloured flannels for different body areas (i.e. anal/genital area and the rest of the body), she also makes the point that gentle use of flannels has been discussed in staff meetings reinforcing the need for HCAs to be empathetic towards potential pain and discomfort. She refers to best practice guidelines that a gentle cleanser be used instead of soap which can exacerbate skin irritation.

a. What is the standard of care/accepted practice?

The standard of care is that patient comfort is paramount when providing any care and that that care does not compromise the resident's condition.

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b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)?

There was a severe departure from the standard of care in the light of [Mr A's] daughters' observation of care being provided:

> '*She took a white face flannel from the basin and proceeded to vigorously rub Dad's bottom which caused him to scream out very loudly … The caregiver ignored Dad's pleas and made no attempt to be gentle. She again rubbed the raw skin with the flannel*'

[The CEO] explains that there may have been a shortage of blue flannels and white flannels had been supplied by the linen supplier to make up for this. This may explain the use of white rather than blue flannel. It is assumed that soap was being used. The use of soap and vigorous rubbing amount to the potential for further damage to already fragile skin. It was clear that [Mr A] was in pain and this was ignored by the caregiver. Both actions indicate lack of empathy, causing pain and exacerbating an existing skin condition.

c. How it would be viewed by my peers.

My peers in education and practice would agree that this was below the expected standard of care.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

In her submission to HDC [the CEO] states that education of HCAs has taken place in terms of providing empathetic, safe care. RNs have also been advised to discuss alternative cleansing resources with families in order to implement best practice guidelines.

The continuation of these measures will help prevent similar occurrences in the future.

3. On 9 April 2019, a gerontology nurse specialist from [the public hospital] assessed [Mr A's] pressure injuries, with assistance from two [rest home] RNs.

a) Whether the assessment by the gerontology nurse specialist was adequate/ appropriate

a. What is the standard of care/accepted practice?

Standard practice is that a wound specialist is contacted by a facility and asked to provide advice on wound care when existing measures are not promoting healing or when a pressure injury meets the requirements for HealthCERT notification (all stage 3 and stage 4 pressure injuries, unstageable pressure injuries and suspected deep tissue injuries). [Mr A's] pressure injuries did not meet these criteria. The gerontology nurse specialist referral was made by the GP [Dr G]. I am assuming [Dr G] contacted [the gerontology nurse specialist] (GNS) for a second opinion on the status of [Mr A's] wounds.

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The GNS provided a one-off assessment of [Mr A's] wounds. Her objective assessment was that the wound was moisture dermatitis and that the dressing being used was appropriate. She provided recommendations relevant to preventing pressure injuries, providing comfort and maintaining fluid balance.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)?

There has been no departure from accepted practice. [The gerontology nurse specialist] had appropriate experience, skills and qualifications to undertake the wound assessment and her findings and recommendations were objective and consistent with accepted practice.

c. How it would be viewed by my peers.

My peers would agree with this conclusion.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

b) Whether the actions of the [rest home] RNs during the assessment, including if they assisted wearing gloves, were adequate/appropriate.

The actions of [rest home] staff during the assessment were to provide assistance to the GNS while she was conducting her assessment. This included holding and moving [Mr A's] buttocks. The nursing staff were not required to touch the wound area.

a. What is the standard of care/accepted practice?

As [the CEO] states best practice is to wear disposable gloves when dealing with any blood and all other body fluid and toxic agents or for contact precautions.

In the situation of the GNS assessment best practice is non touch and gloves are not required and hand hygiene is carried out before and after the procedure.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)?

There has be no departure from accepted (best) practice in this situation.

c. How it would be viewed by my peers?

My peers would agree with this conclusion.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

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4. On 22 April 2019, [Mr A's] family member arrived to find a HCA leaning over [Mr A] seated in his wheelchair, yelling at him loudly.

a) Whether the HCA's actions were adequate/appropriate

a. What is the standard of care/accepted practice?

The standard of practice is that caregivers use communication techniques that are positive and reflect an attitude of empathy and caring. It is particularly important that these skills are utilised in the care of a resident with dementia and that carers understand the disease process and its effects on behaviour.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)? There was a moderate departure from accepted practice in the communication used by the HCA towards [Mr A]. This was identified in the investigation of [Ms B's] complaint and the subsequent actions.

c. How it would be viewed by my peers?

My peers would agree with this conclusion.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations beyond the actions taken by [the rest home].

b) Whether [the rest home's] actions following this incident were appropriate.

a. What is the standard of care/accepted practice?

Accepted practice is that response to a complaint involves investigation including interview of those involved and where required a letter of warning and implementation of a performance improvement plan. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)? There was no departure from accepted practice. [The rest home] has provided clear evidence of the process of investigation, details of the performance improvement plan and a summary of its implementation.

b. How it would be viewed by my peers?

My peers would agree.

c. Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

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5. On 30 March 2019, there was an RN instruction in [Mr A's] progress notes to reposition him every four hours. Whether the repositioning was adequate following the above instructions.

The progress notes between the 30th March and 4th April do not mention that 4 hourly position changes were taking place. The turning chart was not commenced until 4th April following the discovery of [Mr A's] pressure injury. From this point the turning chart was filled in every 2 hours in accordance with the direction that [Mr A] be repositioned every 2 hours.

a. What is the standard of care/accepted practice?

Accepted practice would have been to begin the turning chart on March 30th following the decision to reposition [Mr A] every four hours. This instruction should also have been included in [Mr A's] care plan.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)?

There was a moderate departure during the days between 30th March and 4th April when there was no clear documentation that [Mr A] was being repositioned four hourly. There was no departure from the 4th April when a turning chart and pressure relieving measures were implemented.

c. How it would be viewed by my peers

My peers would agree with the need for adequate and accurate documentation of the pressure area prevention measures in place.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

There is a need for re-enforcement of the need to document planned interventions in a care plan and to introduce appropriate monitoring tools such as the turning chart.

6. [The rest home] conducted an internal investigation and provided its report to [Mr A's] family in April 2019. Were the actions taken by [the rest home] in relation to the internal investigation adequate/appropriate?

The report provided to [Mr A's] family (dated 16th April 2019) states that the investigation included review of medical records and interviewing of all staff involved in [Mr A's] care. The report responded to the issues raised around inadequate communication, inadequate documentation and unsatisfactory clinical cares. Each of these allegations were substantiated. The allegation that the wound on the right buttock was a Stage 3 pressure injury and that [the rest home] was not fulfilling its Section 31 reporting allegation was unsubstantiated. The wound was identified as Stage 1 or 2 by the GP and the GNS and therefore did not meet the criteria for a HealthCERT notification. It is noted that despite this a HealthCERT notification did take place after advice was sought from the Ministry of Health 'given the circumstances and in case of further development of the pressure injury' (page 20 of [the CEO's] response 16 August 2019).

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Corrective actions in relation to the substantiated allegations were listed including disciplinary processes with 3 registered nurses, details of education provided to HCAs and RNs in relation to skin integrity, handover reporting and documentation procedures and review of the handover process. In relation to the unsubstantiated allegation there was a change in terminology used to describe pressure injuries from grade to stage to align with Guiding Principles for Pressure Injury Prevention and Management in New Zealand, 2017.

a. What is the standard of care/accepted practice?

Accepted practice is that an internal investigation is carried out and where needed corrective actions are put in place.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure would I consider this to be (mild, moderate or severe)? There is no departure from accepted practice. The report clearly documents the steps taken in the investigation and appropriate corrective actions.

c. How it would be viewed by my peers?

My peers would agree that the investigation was robust.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

7. In relation to the above and previous advice, whether I consider any of the departures from the standard of care or accepted practice to be attributable to individuals and if so to identify these individuals.

The departures I have identified are in relation to

- the incident of 20 April 2019. Responsibility for this departure lies with the HCA involved who was investigated and provided with a written warning and required to undertake further education and reflection.
- The caregiver's action of vigorously rubbing the pressure injuries with a flannel and causing pain to [Mr A]. The responsibility for this departure rests with the HCA involved.

Other than the 2 HCAs involved in these incidents I do not believe that any departures from the standard of care or accepted practice can be attributed to any individuals.

Please let me know if you require clarification or further comment.

Yours sincerely

Rachel Parmee"

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The following further advice was received from RN Parmee on 3 April 2020:

"Thank you for the opportunity to provide further advice on this case for which I provided initial advice on 24th November 2019 and further advice on 3rd April 2020.

I have been provided with further information and asked to advise whether this changes my previous advice in any way.

The information I have been provided consists of

1. [The rest home's] response dated 28th August 2020
2. A response from [Ms D] dated 28th August 2020
3. A statement from [Ms E] dated 16th October 2020
4. Clinical records
5. Employment and training
6. Policies

The response from [the rest home] provides background to the complaint received from [Mr A's] daughters, an update on [Mr A's] status and information on staff involved in the subsequent investigation.

The response addresses further information requested by HDC.

1. Standard of care provided to [Mr A] 2017 to 2019 inclusive.

This information does not change my advice. I continue to agree that in situations where it was initially identified that the standard of care was unsatisfactory this was acknowledged, and appropriate measures taken to prevent the situations reoccurring.

2. Standard of care provided by [Ms D] to [Mr A] in 2018.

In my response of 3rd April 2020, I stated:

In my initial report I was asked to comment on the alleged assault by a caregiver, and the subsequent management of this incident by [the rest home]. My comment was that there was no departure from expected practice as the incident was documented and investigated in a fair and appropriate manner following the supplied Code of Conduct, House Rules and Disciplinary Action process.

I am now asked to comment on the actions of the health care assistant during the incident. Clearly the actions of [Ms D] were inappropriate as evidenced by the statements of [RN I], [RN K] and [Mr J]. It appears that the HCA used unnecessary physical restraint by placing her foot on [Mr A's] arm while attempting to apply a hoist sling. The bruising on [Mr A's] arm was consistent with these accounts.

As I stated in my initial report the incident was investigated and it was found that the HCA's actions amounted to serious misconduct and she was dismissed immediately.

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In summary the actions of the HCA were inappropriate and appropriate action was taken in terms of investigation and subsequent dismissal of the HCA.

Rachel Parmee
13/11/2020

I still maintain that in terms of the response to this incident there was no departure from accepted practice. In terms of the incident itself there was a severe breach of accepted practice which was addressed appropriately by [the rest home].

In the response from [the rest home] (28th August 2020) it states that [Ms D] was given relevant training and support during the time of her employment and that the 2 incidents relevant to this case were investigated as per policies and procedures.

I have now been provided with a statement made by [Ms D]. Her account of the events and the subsequent investigation process raises questions about her involvement and the fairness of the process.

In terms of the initial complaint by [Mr A's] family I still maintain that the incident was responded to using the appropriate Disciplinary Action process.

I also agree that serious misconduct occurred, but given [Ms D's] version of events and supporting statements I am no longer willing to agree with the investigation process leading to a finding of serious misconduct without the issues she raises in her response being addressed.

3. Incident of 22nd April 2019 [Ms E]

In my report dated 3rd April I stated

There was a moderate departure from accepted practice in the communication used by the HCA towards [Mr A]. This was identified in the investigation of [Ms B's] complaint and the subsequent actions.

The response from [the rest home] (28th August 2020) provides details of [Ms E's] orientation, performance review and responses to incidents. The statement provided by [Ms E] refers to the incident of 22nd April. She has provided her perspective on the incident and her reflection on the investigation process. I am satisfied that [Ms B's] complaint was managed in an appropriate manner and the performance improvement plan was appropriate.

Again, in terms of the initial complaint by [Mr A's] family I believe the response was appropriate.

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4. Overall care provided to [Mr A], including mobility, assessments, care planning and pain management.

The comprehensive information in the response from [the rest home] is supported by the clinical records and policies provided to show that the overall care provided to [Mr A] is of a very high standard.

Please let me know if you require any further information.

Rachel Parmee"

The following further advice was received from RN Parmee on 19 November 2020:

"Thank you for the opportunity to provide further advice on this case for which I provided initial advice on 24th November 2019.

I am asked to advise whether my advice on the incident which occurred on 4th April 2019 is changed in the light of the statement from the caregiver involved.

In my advice dated 3rd April 2020 I stated:

There was a severe departure from the standard of care in the light of [Mr A's] daughters' observation of care being provided:

'She took a white face flannel from the basin and proceeded to vigorously rub Dad's bottom which caused him to scream out very loudly … The caregiver ignored Dad's pleas and made no attempt to be gentle. She again rubbed the raw skin with the flannel.'

[The CEO] explains that there may have been a shortage of blue flannels and white flannels had been supplied by the linen supplier to make up for this. This may explain the use of white rather than blue flannel. It is assumed that soap was being used. The use of soap and vigorous rubbing amount to the potential for further damage to already fragile skin. It was clear that [Mr A] was in pain and this was ignored by the caregiver. Both actions indicate lack of empathy, causing pain and exacerbating an existing skin condition.

The statement from the caregiver [Ms F] provides a different version of events in that she states she used wipes rather than a flannel and did not rub vigorously.

The accounts from [Mr A's] daughter and [Ms F] are very different. It is not, I believe, my role to decide which is the most accurate.

In the light of the information provided by [Mr A's] daughter I maintain that there was a severe departure.

In the light of the information provided by [Ms F] I see no departure as appropriate methods were used to clean [Mr A] and she was cleaning his bottom rather than rubbing his raw skin.

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Please let me know if you require clarification or further comment.

Yours sincerely

Rachel Parmee”

On 12 November 2021, RN Parmee retracted her advice in regard to [Dr G’s] instructions to nursing staff on 12 April 2019, as this was documented on 18 April 2019 after the pressure injury had resolved.

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Appendix B: In-house clinical advice to Commissioner

Dr David Maplesden provided the following advice:

> "1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided by to her father, [Mr A], by staff of [the rest home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the documentation on file: complaint from [Ms B]; response and notes from [the rest home]; statement from [Dr G].
>
> 2. I have been asked to comment on the care provided to [Mr A] by [Dr G] of [the medical centre] both generally but specifically in relation to management of ulcers [Mr A] developed on his buttocks and which were apparently opportunistically discovered by visiting family members on 4 April 2019. Nursing aspects of [Mr A's] care have been reviewed in separate nursing expert advice.
>
> 3. [Mr A] had a history of dementia (mixed Lewy Body and vascular), left hemiplegia, prostate cancer and peripheral neuropathy. He was a resident of [the rest home] since August 2017. [The medical centre] [was] contracted to provide GP services and [Mr A] was seen on several occasions by GP [Dr G] as part of that service. GP notes are available from 15 February 2019. Notes following routine review on 15 February 2019 and 22 March 2019 are of reasonable quality and do not raise any concerns regarding either standard of clinical documentation or clinical care provided. On 22 February 2019 there was a consultation for possible depressed mood symptom reported by family members. Recommendation to monitor mood and consider antidepressant if indicated was a reasonable management strategy.
>
> 4. 22 March 2019 — RN entry includes: *O — seen and examined by [Dr G]. For review, medication changes on Medimap, overall health condition [illegible] fine.* There is a record of vital signs. *A. Stable P — Cavilon applied to scratch bottom … Continue with current plan of care.* [Ms B] states in the complaint that [Dr G] (during a discussion on 5 April 2019) denied being informed on 22 March 2019 that [Mr A] had any issue with his buttock skin. The complaint includes: *[Dr G] said she had been told [Mr A] had 'discomfort'. She said she examined his heart, thinking he may have chest pain from angina, and his lungs thinking he may have pulmonary embolus …* I note the complaint refers to [Mr A] complaining of 'bottom' pain to family members on several occasions prior to 22 March 2019 and based on the complaint, it appears he was able to localise and verbalise his pain. GP notes dated 22 March 2019 include a record of vital signs and cardiorespiratory assessment. Narrative includes: *Still sleepy at times, Mood ?improved.* The notes appear somewhat truncated (no 'Assessment' or 'Plan' documented as there had been on previous notes) and I may have been provided with an incomplete record (pg 505 of 567 PDF3). On the basis of the information available to me, I am unable to confirm that [Dr G] was asked to review [Mr A's] buttock injury on 22 March 2019 and I am therefore unable to comment on adequacy of her assessment or treatment advice. If there were specific health issues (such as pain or buttock injury) brought to [Dr G's]

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attention by nursing staff, and there was an assessment directed at these issues, I would be mildly to moderately critical of the absence of clinical documentation completed by the GP accurately reflecting this situation. It is unclear why [another GP] is recorded as prescribing regular analgesia for [Mr A] on 22 March 2019 when it does not appear he was involved in [Mr A's] assessment on that date.

5. On 5 April 2019 there was discussion between [Ms C] and [Dr G] regarding the likely cause and stage of [Mr A's] ulcers and the complaint suggests there was some disagreement between the two regarding these issues. [Ms C] had recorded a description of the ulcers the previous day and had also photographed the ulcers. She described the ulcers as: *There are two ulcers, one on each buttock. The ulcers are situated on the buttocks. In the anal cleft is a smear of bowel motion and red skin. The buttock skin is loose and dry. Surrounding the ulcers, the skin is a dusky deep purplish colour. The ulcer on the right buttock is larger, roughly triangular in shape, approximately 5cm x 3.5cm and 0.5cm deep. The edges are distinct. There is clear demarcation between ulcer and surrounding skin. As soon as the flannel rubbing stopped there was active bleeding along the edges but not from the base of the ulcer, which is red. I carefully examined the right buttock ulcer and palpated the skin surrounding it. At the medial end of the ulcer (the point of the triangle) there is a circular 'notch' of full thickness skin loss. Superior to the notch is a thick proximally based flap of skin which 'fits' the notch. The 'notch' and the adjacent 1–2cm of skin either side of it can be easily moved independently from the base of the ulcer. This indicates undermining (full thickness skin loss at least in this area).*

6. Nursing notes dated 5 April 2019 include: *At 1700hrs, GP came and check [Mr A's] buttock and GP said that it looks like PI Stage 2. Photograph taken and wound care done. [Dr G] asked consent via phone call to daughter [Ms C] to send photo to Plastics registrar. [Dr G] discuss to [plastic surgery registrar] regarding the photo sent and said that was an element of retained moisture dermatitis associated with pressure. A: retained moisture dermatitis associated with pressure. P: New wound care plan started …* GP notes dated 5 April 2019 include a record of [Mr A's] vital signs and: *He has developed 2 x areas ulceration inner buttocks with erosion of skin. RHS 3cm x 1.5, LHS 1cm x 0.75 & 0.5 x 0.5 cm almost coalesced. Looks like II PI also associated dry lax skin → sheer stresses not over prominence but pulling sheer forces … Family fortunately took pictures yesterday and clearly eroded ulcer over buttock evident — much improved today. This AM reviewed by 2 different nurses & shiny appearance and noted incontinence dermatitis, PI Mx had been instituted and all note improvement today … I note phone picture does look worse today than the wound …* Referral was made for wound care specialist review and photographs sent to the plastic surgical registrar at [hospital] for advice. Wound swab was taken and advice provided regarding pain management. [Dr G] elaborates further on her assessment and management of [Mr A] as per the extracts below from her statement dated 27 May 2019 which appears consistent with the contemporaneous clinical documentation.

7. Extracts from [Dr G's] statement regarding her assessment of [Mr A] on 5 April 2019 include: *A stage II, was my recommendation. Not having seen the gentleman the*

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previous day I could venture a bad GRADE 2 from a phone camera picture the day before, at most a 2.5 (my own validation of its presentation), as the picture taken on a family member's phone looked worse again on 5th April than the examination of the wound on 5th April. The family's phone picture of the 4th April, a phone camera one, from memory showed exposed dermis and significant erythema. On 5th April, a Stage 3 as defined below, was definitely not the case and as discussed with [the plastic surgery registrar] would not have improved to the point that it looked on the 5th, had it been a grade 3 … My impression around aetiology was a combination of moisture dermatitis and shear and pressure. The shear contribution was again noted with subsequent development of a split in the cleft. What I did observe throughout the discussion, was the worsened presentation on the phone camera on two occasions … My communication with [the plastic surgery registrar] of [hospital] plastics was a telephonic one, in which a picture was taken of the buttock area on the tablet and sent to him and he provided an opinion of 'at worst' a Grade 2 with a large component of 'moisture dermatitis', shearing issues from its position on the buttocks, and some pressure injury and then the rest of the conversation provided advice on the allevyn dressing with hypofix and cavilon protection from faeces etc and the regular turns 2hourly. DR … emphasised the moisture dermatitis contribution to the area and the importance of shear injury also entered the discussion, in the context of careful turns and further ongoing pressure injury protection (2 hourly turns etc) and avoidance lying on the area. He emphasised the predisposing moisture dermatitis and need for protection against it and cavilon use. There was no written communication between [the plastic surgery registrar] and myself other than a picture sent on the tablet for his perusal.

8. The referral by [Dr G] for Wound Care Specialist review of [Mr A] includes: *Many thanks for your review of* [Mr A] *with grade 2–2½ PI both inner buttocks. D/W Plastics Reg [hospital] for Allevyn dressing today and then review/further management of underlying chemical (incontinent) dermatitis/inflammation which has triggered an exacerbated pressure injury with moisture aggravation.*

9. My impression is there was acknowledgement there had been some improvement in the ulcers and surrounding skin appearance (due to moisturising and dressings) between 4 and 5 April 2019 but it appears [Ms C] remained of the view the pressure area was stage 3 while [Dr G] felt it was stage 2–3. There was also disagreement as to whether the ulcers represented primarily pressure injury (PI — [Ms C's] view) or IAD ([Dr G's] view). [Ms B] expresses concern that during [Dr G's] later phone consultation with [the plastic surgery registrar] the clinical picture was somewhat misrepresented by [Dr G] so that moisture dermatitis was agreed to be the primary diagnosis (rather than pressure injury) and this adversely affected [Mr A's] subsequent management. I am unable to determine from the available clinical information that there was any minimisation or misrepresentation of [Mr A's] buttock ulcers by [Dr G]. It appears the registrar was provided with photographs of the ulcers together with a narrative from [Dr G] regarding her clinical findings and impression. This is accepted practice. It is not possible for me to accurately determine the aetiology or stage of [Mr A's] ulcers on the basis of the historical photographs and clinical records and it would be inappropriate for me to state the opinion of either [Ms C] or [Dr G] was in error. In my opinion, the

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management of [Mr A] by [Dr G] on 5 April 2019 was appropriate for a patient with a stage 2 injury related to pressure or shearing injury and/or IAD, and the clinical findings and management plan were appropriately documented.

10. [The Gerontology Nurse Specialist] assessed [Mr A] in response to the referral. An extract from her report reads: *I visited [Mr A] on 10th April 2019 for the purpose of a wound assessment, and advice. My visit was accompanied by [Mr A's] wife and daughter, and the Clinical Manager. The wound on his buttocks was redressed with a 5cm x 5cm Allevyn adhesive dressing. The dressing had been present for four days. Upon inspection, the area had massively decreased in size, and there was great evidence of epithelisation. The area was practically healed and flush with the surrounding skin. My impression was that wound was a combination of pressure and dermatological reaction to urine and sweat. The use of an air mattress and regular turning no doubt contributed to the rapid healing process.*

11. [Ms B] expresses concern at [Dr G's] assessment of [Mr A] on 12 April 2019 when he had had a reduced level of consciousness for several days and fluid intake (per intake charts) was markedly reduced. I could find no reference in the nursing notes to a GP assessment having been undertaken on this date. Nursing notes do include: *to monitor fluid intake, if less than 850 mls … to start subcut fluids 500mls overnight.* On review of prescribing records, it appears [another GP] prescribed subcut fluids on 12 April 2019 as per the nursing note. There are extensive clinical notes recorded by [Dr G] on 12 April 2019. This includes vital signs (no hypotension or tachycardia), weight (comparative loss noted) and recent fluid intake. Subcut fluids were recommended as noted above. A majority of the notes relate to assessment of [Mr A's] buttocks and discussion with family regarding the most likely cause (PI versus IAD) and ongoing management in this regard. [Dr G] has not addressed the issue of her assessment of [Mr A's] hydration in her statement. Best practice would be to document factors such as peripheral perfusion, skin turgor and state of oral mucous membranes if undertaking a detailed assessment of hydration, together with reference to the degree of dehydration determined. Although [Dr G's] standard of clinical documentation overall is superior to that I see in many other clinical notes I have reviewed from various long-term care facilities, I am mildly critical that there is no record of the assessed degree of dehydration but [Mr A's] overall management on this date appears otherwise appropriate.

12. The complaint includes concern at the accuracy of [Dr G's] description of [Mr A's] physical capabilities with reference to a note by [Dr G] dated 18 April 2019 (*does turn self*) which [Ms B] states is inaccurate and an attempt, together with the inaccurate wound descriptions, to distract from the most likely cause of [Mr A's] ulcers as being due primarily to pressure injury. [Dr G's] notes dated 18 April 2019 are confirmed to contain the statement referred to and indicate a comprehensive assessment was undertaken and documented on that date. In the absence of a response from [Dr G] addressing this specific issue describing the basis for her statement (personal observation? report from nursing staff?) I am unable to comment further on this aspect of the complaint.

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13. In summary, I feel the overall management of [Mr A] by [Dr G] did not depart from accepted practice although the absence of a response from [Dr G] related to some specific aspects of the complaint is a limiting factor. There may be some mild deficiencies in clinical documentation. I recommend clarification is obtained from [the medical centre] as to why [the second GP] is recorded as prescribing [Mr A] regular paracetamol elixir on 22 March 2019 and subcut N saline PRN on 12 April 2019 when he was apparently not involved in [Mr A's] care on those dates."

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Appendix C: Relevant standards

The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) state:[1]

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 the organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> …
>
> Standard 2.4 all adverse, unplanned, or untoward events are systematically reported by the service and reported to affected customers and where appropriate their family/whānau of choice in an open manner.
>
> …
>
> Standard 2.8 consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers."

The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "1.10 Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers.
>
> …
>
> 4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.8 Keep clear and accurate records.
>
> …
>
> 4.10 Practise in accordance with professional standards relating to safety and quality health care."

[1] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.

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Appendix D: Relevant policies/procedures

Mercy Parklands Limited's Nutritional Assessment in Elderly policy[1] states:

> "Food and fluid intake monitoring:
>
> RN to commence food and fluid intake monitoring for identified residents with decreased intake and document in integrated notes every shift.
>
> …
>
> Reporting:
>
> Any significant unplanned weight should be evaluated for possible causes and reported to the GP/discussed with advocate/whānau."

Mercy Parklands Limited's Assessment Resident policy[2] states:

> "Assessment Resident
>
> The team accurately and appropriately assesses the resident's needs.
>
> …
>
> Assessment ongoing
>
> Information should guide the resident and the appropriate team members in developing plans and setting goals."

Mercy Parklands Limited's Pain Management policy[3] states:

> "Assessment
>
> …
>
> For residents who are unable to verbalise their level of pain or the effectiveness of interventions we use the Abbey Pain Scale.
>
> A resident's perception of pain is documented on the assessment form.
>
> A pain level is identified."

[1] Issued in May 2006 and reviewed in May 2019.
[2] Reviewed in July 2017.
[3] Issued December 2007 reviewed in August 2018.

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Mercy Parklands Limited's Pressure Injury Prevention and Management policy[4] states:

> "Assessment
>
> Residents who are bedfast and/or chairbound are to be considered at risk of pressure injury development.
>
> The risk assessment information will be supported by sound clinical judgment and utilisation of the pressure injury Checklist to inform care planning.
>
> …
>
> Prevention and Management
>
> Prevention of pressure injury:
>
> Prevention of pressure injury should be promoted through an overall approach, and should be considered the 1st priority to reduce the need for more timely and costly management strategies.
>
> Management of Pressure Injuries:
>
> Interventions must be co-ordinated, documented and regularly evaluated for effectiveness.
>
> …
>
> Repositioning:
>
> The use of repositioning is required in all at risk residents, and should be taken to reduce the duration and magnitude of pressure over vulnerable areas of the body.
>
> …
>
> Consultation:
>
> All information from the assessment and monitoring of the prevention and management of pressure areas will be fully documented in the resident's care plan and comprehensively communicated within the multidiscliplinary team."

Mercy Parklands Limited's Wound Management policy[5] states:

> "Documentation:
>
> Wound management
>
> Initial assessment
>
> Treatment plan and evaluation of care."

[4] Reviewed in May 2019.

[5] Issued July 2003 and reviewed in January 2018.

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