Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 19HDC01980)

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Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report discusses the care provided to Ms A by Bupa Care Services NZ Limited (Bupa).

2. The following issue was identified for investigation:

- *Whether Bupa Care Services NZ Limited provided Ms A with an appropriate standard of care in 2019.*

Names have been removed (except Bupa Care Services NZ Limited and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Background

3. Mr B, Ms A's activated Enduring Power of Attorney (EPOA[1]), raised a complaint to HDC about the care Ms A received from a care home.[2] Ms A, aged in her fifties at the time of events, had resided at the care home since 2015 and received hospital-level care.[3]

4. Ms A's medical history includes an intellectual disability with low IQ, schizoaffective disorder,[4] limited mobility, diabetes, heart disease, and morbid obesity. Ms A also has pemphigoid, an autoimmune condition that causes blistering and rashes on the skin, and chronic venous eczema, which contributes to recurrent cellulitis[5] and predisposes her to pressure areas, skin breakdown and infections.

5. This report considers two key issues: the care Ms A received in relation to skin wounds on her legs (in particular, the events leading up to maggots being discovered in the wounds on 23 March 2019), and Bupa's management of the termination of her admission in August 2019.

Responses to provisional opinion

6. Mr B was provided with a copy of the information gathered during the investigation, and he advised that he had no comments.

7. Bupa was provided with a copy of the provisional opinion, and its comments have been incorporated throughout this opinion where appropriate.

8. RN C was provided with a copy of relevant sections of the provisional opinion, and she advised that she had no further comments.

Opinion: Bupa Care Services NZ Limited

Introduction

9. I have undertaken a thorough assessment of the information gathered in light of Mr B's concerns. I have also considered the independent advice provided by Registered Nurse (RN) Rachel Parmee. I have found Bupa Care Services NZ Limited (Bupa) in breach of Right 4(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code). The reasons for my decision are set out below.

[1] For personal care and welfare.
[2] The care home provides hospital and rest-home level care and has several rooms with dual-purpose beds. The use of dual-purpose beds is recognised under the Age Related Residential Care (ARRC) contract and governs funding arrangements between providers and DHBs.
[3] This was funded by the District Health Board (now Health New Zealand|Te Whatu Ora (Health NZ) under Long Term Support — Chronic Health Conditions (LTS-CHS).
[4] A mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania.
[5] A common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin.
[6] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Daily skin inspections and documentation from 16 to 23 March 2019 — breach

10. Ms A is susceptible to cellulitis,[7] and she reported that just before she develops cellulitis, she experiences symptoms, including a specific sensation in her leg.[8]

11. Between 16 and 23 March 2019 nursing staff completed progress notes[9] daily and documented Ms A's back pain and the measures taken to alleviate it. However, these progress notes did not make any reference to Ms A's skin condition.

12. Care sheets were also completed by care staff between 16 and 23 March 2019. Care sheets contain a list of tasks such as shower, bed bath, wash, pressure area care, etc. The care sheet did not contain an area for the care staff to document whether a skin integrity check had been completed. The care sheet stated: '[K]indly report any concerns or unusual changes for your residents to the R[egistered] N[urse].'

13. Bupa stated[10] that in a care home, it is the responsibility of the care staff, as opposed to the registered nurses, to undertake daily skin integrity checks and then to report any concerns to the nursing staff.

14. Bupa said that as a non-acute service healthcare provider, it used 'exception reporting' for clinical documentation. This meant that the care staff were not required to duplicate the care sheet recording in the resident's progress notes unless there was a variance, for example if a resident required more assistance during their shower. Bupa highlighted that under this approach there is no requirement to record the results of daily skin checks if there are no changes of note identified.

15. Bupa told HDC that its expectation was for care staff providing care to Ms A to report any changes, complaints, or concerns to the registered nurse, Clinical Manager, or Care Home Manager to ensure that appropriate follow-up action was undertaken, especially as Ms A had a history of cellulitis requiring hospital admission for treatment.

21 March 2019

16. Ms A recalled that on 21 March 2019 she felt the sensation in her right leg that a wound or cellulitis had started to develop, and she asked a nurse to check, and the nurse refused. Bupa told HDC that the nurses who worked on 21 March 2019 (RN C and RN D) do not recall Ms A asking them to check her legs.

17. The progress notes from 21 March 2019 do not make any reference to Ms A having any signs of wounds or open skin lesions. At 8am, RN C documented that Ms A had not complained of pain. At 9.37pm, RN D documented: '[N]il complaints of pain/discomfort, seems comfortable. Settled. Nil concerns noted.'

[7] Ms A developed cellulitis in December 2018 and January, February and March 2019.
[8] Ms A had required hospital admission for cellulitis in the past.
[9] Care staff also made notes in the progress notes, but during this period there were no entries in the progress notes by care staff.
[10] In a meeting with Ms A on 9 April 2019.

22 March 2019

18. Ms A recalled that on 22 March 2019 she asked two nurses to check her leg, but both refused. Bupa told HDC that the nurses working on 22 March 2019 (RN C and RN D) do not recall Ms A asking them to check her legs. There is no record of any wounds or open skin lesions in the progress notes. At 6.30am, RN C documented that Ms A appeared comfortable, and at 9.46pm RN D documented that Ms A had 'nil complaints of pain/ discomfort, settled and nil concerns noted'.

23 March 2019

19. During its investigation, Bupa checked the CCTV footage, which shows that a care assistant provided hygiene care assistance at 8am on 23 March 2019. Bupa's investigation found that this caregiver had noticed that there was redness on Ms A's leg but no broken skin. The caregiver did not inform the registered nurse (RN C) about the redness and did not document it.

20. At 10pm on 23 March 2019, RN D documented that RN C (the morning nurse) had informed her of a leaking wound on Ms A's right leg. RN C had not documented this finding and instead documented: '[Ms A] appeared settled. Nil concerns.'

21. RN C did not undertake a wound assessment or devise a wound management plan as per Bupa's Management of Wounds Policy.

22. In response to the provisional opinion, Bupa acknowledged that although RN C reported the leaking wound to RN D, she did not document it as she was expected to.

23. After Mr B raised concerns, Ms E, the Care Home Manager, carried out an investigation. In the incident report dated 1 April 2019, Ms E documented that she spoke to the morning nurse from 23 March 2019, who could not recall the incident, and a member of care staff who 'does not recall any reports of [a] wound on [Ms A's] leg, recalls giving pain relief'. Ms E documented that a different member of the care staff 'denied seeing any broken skin on [Ms A's] leg during [a] wash [and a] file note [was] made for not reporting redness on [her] leg during cares'.

24. Ms E wrote to Mr B on 8 April 2019 and stated that she had determined that there had been inadequate reporting of Ms A's skin condition on 23 March 2019, and on that morning a member of the care staff had noted redness on Ms A's leg but no broken skin. Ms E stated that the redness should have been reported to the nurse but was not.

25. In response to HDC's investigation, Bupa stated that its investigation found that a staff member[11] reported that Ms A had said that 'something [was] off' with her leg, up to two days prior to maggots being noted in the wound (which would have been on 21 March 2019, at the earliest). Bupa was sincerely apologetic that Ms A's concerns about her leg were not documented or acted on.

[11] The care home did not inform HDC of the names of the staff who recalled that Ms A had noticed changes in Ms A's leg.

Opinion

26. My independent advisor, RN Parmee, advised that it was vital for skin inspections on Ms A to be carried out during each shift and documented (ideally on both the care sheet and in the progress notes), as there was a recognised risk of alteration to her skin integrity. As such, Ms A was at risk of rapid development of complications following any changes in her skin status. RN Parmee advised that any changes should have been reported to the registered nurse, who should have carried out an assessment and initiated appropriate action in accordance with the facility wound care policy.

27. Due to the lack of documentation, I cannot determine whether skin inspections occurred and, if so, how frequently. RN Parmee noted Bupa's use of 'exception reporting' and considers that the failure to document any skin inspections that were undertaken in the period 16 to 23 March 2019, and the failure to document, report, or action the reddening of Ms A's skin that was noticed on 23 March 2019, constitutes a moderate departure from the accepted standard of care. I acknowledge this advice.

28. In its response to the provisional opinion, Bupa accepted that there was a failure to report an exceptional change to Ms A's skin condition on the morning of 23 March 2019, by both the healthcare assistant and RN C, but noted that Ms A was being attended to throughout the day on a range of matters when she was in the home.

29. Bupa also said that its 'exception reporting' approach of reporting only changes of note explains why there were no documented skin checks for Ms A during the period 16 to 22 March 2019. It contends that daily skin checks were carried out properly in this period.

30. I acknowledge Bupa's submission regarding the lack of documented skin checks for Ms A prior to 23 March 2019 being due to its approach of exception reporting.

31. However, I refer to RN Parmee's advice that in the context of Ms A's recognised risk of alteration to her skin integrity, it was vital for skin inspections to be carried out during each shift and documented. I do not consider it appropriate to use exception reporting in the checking and monitoring of previously identified vulnerabilities. In my view, exception reporting is insufficient in this context, and it would be accepted practice to document observations even when these are within normal parameters.

32. I would have expected to see documentation during 16 to 23 March 2019 of daily skin checks by care staff, indicating that no skin issues had been observed, or in cases where these had been identified, that the issues had been escalated to the registered nurse.

33. It was accepted that the risk of Ms A succumbing to a significant skin infection was such that staff caring for her had a responsibility to ensure that daily skin inspections were undertaken and documented, and symptoms acted upon immediately as warranted. Due to the poor documentation, it is unclear whether skin inspections were undertaken but not documented (whether this was because there was nothing of note to report or otherwise), or simply were not undertaken at all. Further, there were at least two incidents (on 23 March 2019) of an issue being identified by staff but not documented. In light of these omissions, I am not confident in Bupa's explanation that its 'exception reporting' approach explains the lack of

skin issues documented from 16 March to late evening 23 March 2019. Rather, I consider that it is more likely than not that notable signs of deterioration in Ms A's skin condition were missed and not documented or reported during that period.

34. While Bupa stated that there does not appear to be any evidence or submission that daily checks were not carried out, I note that the problem with Bupa's approach of exception reporting is that there is also no evidence that daily checks *were* carried out. The lack of documentation with this approach means that there is only a reliance on the fact that the policy in place is being complied with, and as is evident from the events of 23 March 2019, this can be unreliable.

35. Further, even if these checks were carried out in compliance with Bupa's policy (but not documented), I remain concerned that there was a lack of responsiveness from nursing staff when Ms A raised concerns about the condition of her skin.

36. Ms A stated that she reported concerns about her legs to nursing staff on two separate occasions (once on 21 March 2019, to one member of nursing staff; and once on 22 March 2019, to two members of nursing staff). She said that on both occasions, the nursing staff refused to examine her legs. The nursing staff working on those dates cannot recall being asked to look at Ms A's legs, and there is no record of this in Ms A's notes. However, during Bupa's investigation, a member of care staff recalled Ms A having raised concerns about her legs up to two days before the maggots were discovered on 23 March 2019.

37. In response to the provisional opinion, Bupa disagreed with Ms A's statement that she had reported concerns about her legs to nursing staff. Bupa emphasised that her recollection was inconsistent with that of Bupa staff, despite the comment made in its own investigation referred to in the previous paragraph. Bupa stated that Ms A's concerns would have been acted upon if she had raised clear concerns with multiple nurses, and it noted that its staff were alert to the risks to Ms A's skin and were providing her with daily care. Bupa also noted that Ms A had been seen by her GP on 20 March 2019, at which point her legs were checked and no issues were identified.

38. Bupa accepted that 'to the extent [Ms A] raised any concern this should have been documented' but said that 'it is unsafe and unreasonable to conclude that a lack of specific documentation is somehow evidence that [Ms A] must have raised detailed concerns that were not listened or responded to'.

39. I acknowledge that Bupa disagrees with Ms A's account. However, given the clear issues with record-keeping (ie, the caregiver's failure to document the redness on Ms A's leg and RN C's failure to document that Ms A's wound was leaking on 23 March 2019) and the recollection of a member of care staff that concerns had been raised by Ms A prior to 23 March but there is no associated action or documentation about this, I do not discount the possibility that Ms A reported concerns and that this was not acted upon, or documented. I consider that Ms A's concerns about the changes in her leg were not listened to appropriately or documented and escalated.

40. I have carefully considered the extent to which deficiencies in Ms A's care between 16 and 23 March 2019 occurred as a result of individual staff inaction, as opposed to systemic and organisational issues. Multiple individual providers involved failed to document important information in Ms A's care sheets and progress notes. In particular, I note the following shortcomings:

a) Between 21 and 23 March 2019, care staff recalled that Ms A reported concerns about her legs. There is no evidence of any action having been taken or documentation of the concerns raised.

b) On 23 March 2019, a caregiver noticed reddening of skin on Ms A's leg. The change was not reported to nursing staff, and there is no evidence of any action taken or documentation of the change.

c) On 23 March 2019, RN C noticed a leaking wound on Ms A's leg. She did not undertake a wound assessment or devise a wound management plan, as per Bupa's Management of Wounds Policy. Further, RN C documented that '[Ms A] appeared settled. Nil concerns.' RN C informed RN D of the leaking wound at 10pm that evening.

41. The widespread and repeated nature of these omissions indicates that staff did not understand what was expected or appreciate the possible ramifications. This reflects a pattern of failure to comply with policy, for which, ultimately, I hold Bupa responsible.

42. I also consider that the lack of documented skin inspections during 16 to late evening 23 March 2019 by care staff was the result of an inappropriate organisational approach to using exception reporting in the context of previously identified vulnerabilities that required daily checks.

43. For the above reasons, I find that Bupa failed to provide services to Ms A with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code.[12]

Management of wound — no breach

44. Bupa told HDC that at approximately 1pm on 23 March 2019, the afternoon care assistant noticed discharge coming from Ms A's legs and informed a registered nurse. The registered nurse noted stains on Ms A's sheets but that the skin appeared dry. At approximately 5pm, the nurse re-examined Ms A's leg dressings and noticed the presence of maggots in a small wound on Ms A's right leg.

45. Progress notes in the following days demonstrate that wound care and skin assessments were completed.

46. A wound care plan was not completed until 27 March 2019. Bupa told HDC that its expectation for monitoring and evaluation of wounds is that a formal wound care plan and evaluation documentation would have been completed prior to this date. Bupa apologised sincerely that this did not occur in a timely way.

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

47. RN Parmee advised that the standard of care is that six-monthly interRAI assessments[13] take place, and the resident's care plan is developed or updated accordingly. Skin and wounds should be assessed, and this should be documented on each shift if a resident is at risk of rapid deterioration in skin integrity. RN Parmee considers that the standard of care was met between 23 March and 31 August 2019. She advised that while there was an acknowledged delay in completing formal documentation between 23 and 27 March, she is satisfied that adequate and appropriate care was being provided.

Termination of Ms A's placement at the care home — adverse comment

48. The management of Ms A's relocation to another residency from the care home, after she was admitted to hospital in August 2019, was a key part of the complaint.

49. Bupa told HDC that over time, Ms A's condition changed, and there was no clear mechanism available for staff to reassess the services it provided. Bupa stated that the funding model provided by Health NZ did not allow for supported modifications to be implemented that would meet Ms A's needs adequately, given that those needs were above that of a hospital-level care home resident.

50. Bupa told HDC that Ms A had increasingly frequent admissions to hospital during the latter period of her placement at the care home, and funders were contacted but little satisfactory additional support was identified or implemented as a result. Bupa also said that Ms A's increasing care requirements were discussed with her family and advocates throughout her placement.

51. Bupa told HDC that on 20 May 2019, it approached Health NZ to discuss Ms A's care.[14] Bupa highlighted the changes to Ms A's health condition and the impact this was having on the staff working with her, including the health and safety risk to staff providing direct care. Bupa also noted the impact this was having on care provision to other residents, due to the number of staff required to provide direct care to Ms A.

52. On 22 May 2019, Bupa requested a reassessment of Ms A's needs from Health NZ's Needs Assessment and Service Coordination (NASC).

53. On 7 June 2019, a NASC clinician met with Ms A and conducted a reassessment. Health NZ told HDC that the notes of the meeting indicate that Bupa was struggling to provide safe care to Ms A because of her dramatic increase in weight and reduced mobility.[15]

54. From the information provided by Bupa and Health NZ, it is not clear what, if any, changes to Ms A's care or support were made following this reassessment.

55. On 20 August 2019, Ms A was admitted to hospital. On 21 August 2019, Ms E wrote to Ms A and gave notice that her admission to the care home was being terminated, with effect in

[13] A tool that provides a clinical assessment of medical, rehabilitation, and support needs and abilities, and self-care for clients who require home and community support services.
[14] See footnote 2.
[15] Health NZ did not provide HDC with a copy of the notes of the review.

21 days. The letter stated that the care home could not continue to provide care for Ms A, as it did not have the required equipment to meet her needs. Ms E told Ms A that she could not return to the care home because of concerns for her safety, and that the care home would contact the relevant health agencies to discuss alternative arrangements for her.

56. On the same day, Ms E also wrote to a NASC clinician, and asked Health NZ to make alternative arrangements for Ms A. Ms E reminded Health NZ that the care home had informed it previously that the care home did not have the appropriate bariatric equipment to support Ms A's needs. Ms E noted the following:

- The care home was unable to provide safe support to its staff as Ms A required three to five people to assist her with her care.
- As manager, she had overall responsibility for ensuring that the complex needs of Ms A were met, along with the wellbeing of the other service users and the wellbeing of staff.
- Under health and safety legislation, the DHB (Health NZ) as the principal under the service contract is a Person Conducting Business or Undertaking and has health and safety duties to the care home staff also.
- The care home had been providing 'ceiling care'[16] and, unfortunately, the care home was no longer able to meet Ms A's needs.
- Ms A was currently in hospital, and the care home would not be accepting her to be re-admitted due to safety concerns for Ms A and for staff.

57. On 28 August 2019, the care home's Operations Manager met with Health NZ's Older Persons portfolio manager to discuss the exit process. Bupa told HDC that the Operations Manager has since left Bupa, and there is no record of what was discussed.

58. Health NZ told HDC that after this meeting, NASC was advised to start looking for alternative accommodation for Ms A, and not to discharge her to the care home because this would mean she would have to move to another residential provider on completion of the 21-day notice period, and that the funding to Bupa in respect of Ms A was to be ceased from 20 August 2019.

59. On 6 September 2019, Ms A was discharged from hospital and moved into her new home.

60. That same day, Bupa wrote to Ms A and apologised for any distress caused in how they communicated the message to her. Bupa stated: '[W]e should have met with yourself and the NASC team to discuss thoroughly our intentions for this.'

61. Bupa told HDC that it does not take the termination of residential care contracts lightly, and it had been long established that Ms A's care needs were increasing, and her complexity, both physically and emotionally, were difficult for staff to manage effectively.

[16] The maximum level of care the patient is set to receive.

62. Bupa told HDC that finding another care facility that offered the right level of care was the responsibility of Health NZ and its NASC services.

Opinion

63. I acknowledge that this was a distressing experience for Ms A and Mr B. The care home was Ms A's home, and being informed that she was unable to return, with no certainty of where she would be moving, would have been a confronting experience. I also note that Ms A was particularly vulnerable at this time, having recently been admitted to hospital.

64. I accept that when Ms A was admitted to the care home in 2015, it could safely provide her with care. However, it is clear that Ms A's complex needs escalated over time. I acknowledge that when Ms A's condition changed, such that the care home felt that it was no longer able to provide her with safe and effective care in 2019, Bupa requested input, assessment, and co-ordination of the services available (see paragraphs 50–53). This was the appropriate action for Bupa to take in the circumstances, as the safety and wellbeing of the resident is the paramount consideration. Further, I am not critical of the decision by Bupa not to accept Ms A back into its care after her admission to hospital on 20 August 2019. By this time, it was apparent that the care home was no longer able to meet Ms A's needs safely, and an alternative placement was needed.

65. Having said that, I consider that Bupa could have communicated with Ms A in a more empathetic manner when it notified her that her placement was being terminated. I note that Bupa apologised to Ms A for the manner of its communications with her, and it acknowledged that it should have met with her and the NASC team to discuss what was going to happen. I agree that a face-to-face meeting should have taken place. A consumer's entry into, and exit from, services should always be facilitated in a respectful manner, and it is clear that this did not happen.

Opinion: RN C — adverse comment

Lack of documentation

66. On 23 March 2019, RN D documented that the morning nurse, RN C, told her that the wound on Ms A's right leg was leaking. RN C did not document this finding, and instead documented: '[Ms A] appeared settled. Nil concerns.'

67. The Nursing Council of New Zealand Code of Conduct for Nurses (2012) states that nurses should keep clear and accurate records of any discussions and assessments made (see Appendix B). The guidance states that this includes clear and accurate records of assessments.

68. I remind RN C of her obligation to comply with professional standards.

Changes made since events

69. Bupa told HDC that it undertook the following:

a) Registered nurses were reminded of their obligations to monitor, assess, and report incidents and wounds, and of Bupa's expectations regarding documentation, at two staff meetings.

b) A daily skin observation chart was devised and implemented.

c) The caregiver involved in Ms A's care on 23 March 2019 and the wider care staff team were advised of the importance of reporting deviances from the normal to nursing staff promptly.

d) Staff were provided with the RAIN[17] model for supportive communication.

e) All care staff were reminded of the importance of listening to residents as 'experts in their own care' when concerns are raised.

Recommendations

70. I recommend that Bupa:

a) Provide a written apology to Ms A for the breach of the Code identified in this report, within three weeks of the date of this report.

b) Liaise with Health NZ and jointly devise a policy that outlines the pathway to raise concerns about ability to provide adequate care to a resident (at any Bupa facility), and the pathway for Health NZ to locate alternative accommodation for a resident. Evidence of the new policy/pathway document is to be provided to HDC within three months of the date of this report.

c) Review the reminder provided to registered nurses on their obligations to monitor, assess, and report incidents and wounds, and report the outcome of its review to HDC within six months of the date of this report.

Follow-up actions

71. A copy of this report with details identifying the parties removed, except Bupa Care Services NZ Limited and the advisor on this case, will be sent to Health New Zealand|Te Whatu Ora, HealthCERT, the Nursing Council of New Zealand, and the New Zealand Nurses Organisation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[17] Recognise, Accept, Investigate, Non-identification (a process to support working with intense or difficult emotions).

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Rachel Parmee:

'**1.** Thank you for the opportunity to provide clinical advice regarding the care provided by [the] Care Home to [Ms A] between March 2019 and August 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.

2. I registered as a nurse in 1985. Upon registration I worked as an 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 co-ordinating 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.

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

With comment on:

a. Whether I consider that Bupa carried out adequate skin assessments in the period 16 March 2019 to 23 March 2019.

b. Whether I consider that the wound care and skin assessments carried out in the period from 23 March 2019 to 31 August 2019 were adequate and appropriate.

c. In my opinion, were the actions taken by Bupa as detailed in its "Corrective Action Plan" to prevent a similar incident occurring in future sufficient and appropriate.

d. The adequacy of Bupa's wound management policy

e. Any other matters that I consider warrant comment.

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.

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

1. Letter of complaint dated 21 October 2019
2. Bupa's response dated 28 November 2019
3. Clinical records from Bupa covering the period 1 March 2019 to 31 August 2019
4. Copy of relevant Bupa policies
5. Bupa's Corrective Action Plan
6. Copy of complaint and response letters between Bupa and [Mr B]
7. Minutes of Family and Multi-Disciplinary Team meetings
8. Training and Education records
9. Email communications

5. Background

[Ms A] was admitted to [the] Care Home in July 2015 under a Long Term Support — Chronic Health Conditions (LTS — CHC) contract. [Ms A] had a complex medical history, including morbid obesity, flaccid quadriparesis, schizoaffective disorder, splenomegaly, hypothyroidism, colonised MRSA and ESBL, heart disease, cellulitis, and chronic venous eczema of lower limbs.

On 23 March 2019, a registered nurse observed the presence of maggots in a wound on [Ms A's] right leg. The progress notes and associated care recording forms in the week prior to 23 March 2019 do not record any wounds or open skin lesions. However, Bupa advises that subsequent discussions with relevant staff suggest that [Ms A] had identified something "being off" with her leg up to two days prior to the maggots being discovered.

Following the incident of 23 March 2019, Bupa implemented a number of actions aimed at addressing the issue and minimising the risk of a recurrence.

Review of Documents

6. Whether I consider that Bupa carried out adequate skin assessments in the period 16 March 2019 to 23 March 2019

[Ms A's] chronic health conditions including obesity, limited mobility, heart disease, cellulitis and venous eczema of the lower limbs predisposed her to pressure areas, skin breakdown and infections. It was also noted that [Ms A] suffered with Pemphigoid, an autoimmune condition that causes blistering and rashes on the skin. It was vital that daily skin inspections took place as [Ms A] was at risk of rapidly developing complications to any changes in her skin status. It was also vital that these inspections were documented.

Between 16 and 23 March progress notes were written at least daily. There are reports of [Ms A] experiencing back pain and measures taken to alleviate this. There is no mention of [Ms A's] skin condition until 2200 on the 23rd March. There is no entry made for the morning shift. The afternoon RN noted that the morning RN had "reported" that the wound on the right leg was leaking. The afternoon RN then assessed [Ms A's] legs and found two open wounds each containing maggots. It is recorded in the following days that wound dressings were done and a short-term care plan commenced on 26th March. A wound initial assessment and plan was dated 27th March with subsequent daily evaluations. Care sheets provided by BUPA have a section named "Pressure Area Care" which is consistently marked Y for morning and afternoon shifts.

I note there is a section named "Documentation Completed" which is blank on the majority of days. This does not correspond with the progress notes. I am wondering if the care sheet is for HCAs to complete and progress notes the domain of RNs. This is significant as there does not appear to be detail of what "Pressure Area Care" entailed and whether it included skin inspection.

In the investigation following the incident it was revealed that an HCA had noted redness on [Ms A's] skin, which in her case would have been a cue for reporting and further intervention from the RN. There is no written evidence that the redness was reported to the RN or acted on by the RN. In her correspondence with [Ms A's] EPA [Mr B], Ms E states that following discussion with relevant staff members she had determined that there had been inadequate reporting of [Ms A's] skin condition on the 23rd March and detailed the following events: *On this morning whilst providing hygiene cares to [Ms A], the caregiver noted redness on [Ms A's] leg but no broken skin. Due to [Ms A's] history of cellulitis, the presence of redness should have been relayed to the registered nurse for further assessment and management. Unfortunately, this reporting did not take place at this time. In the afternoon, the registered nurse was alerted to [Ms A] having discharge coming from her legs and checked her around 5pm. The registered nurse noted that while there were stains on [Ms A's] sheet the skin appeared dry. At approximately 7pm, the nurse returned to attend to [Ms A's] leg dressings and noted the presence of the maggots in a small wound on her right leg. Her response to this, a referral to the GP was made promptly, which was appropriate.* Ms E went on to reassure [Mr B] that caregivers had been advised of the importance of reporting any changes in [Ms A's] skin status and that registered nurses were checking [Ms A's] legs each shift

and that a special education session around the risks related to [Ms A's] skin frailty had been planned for staff.

The minutes of the family meeting held 9th April reflect the change in the usual practice of caregivers performing skin checks and reporting to RNs, to RNs performing skin checks in [Ms A's] case.

Once discovered the wound was cleaned and dressed appropriately with reporting and documentation requirements (according to the wound care policy) fulfilled. Measures were also put in place to alleviate the fly burden in [Ms A's] room.

What is the standard of care/accepted practice?

Accepted practice is that where there is a recognised risk of alteration to skin integrity, skin inspections are carried out each shift and documented ideally on both the care sheet and progress notes. Any changes are reported to the RN who carries out an assessment and initiates appropriate action in accordance with the facility wound care policy.

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

There was a moderate departure from the accepted standard in that skin inspections were not documented in the period 16th to 23rd March and that on the 23rd March inspection revealing a reddened area on [Ms A's] leg which was neither reported nor documented. Although the skin inspections were not documented I am not prepared to assume that skin inspections did not take place during this timeframe. Given [Ms A's] pre-existing conditions and history I accept that the deterioration in her skin status would have taken place on the 23rd March rather than during the preceding days.

How would it be viewed by your peers?

My peers in education and practice would agree.

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

Any recommendations I would make have been put in place by BUPA and clearly documented in their response.

7. Whether I consider that the wound care and skin assessments carried out in the period from 23 March 2019 to 31 August 2019 were adequate and appropriate.

The documentation provided in the form of wound assessments and evaluations indicate that daily skin assessments were not recorded until 27 March when daily wound assessments commenced.

As [the Clinical Service Improvements Co-ordinator] states in her response (28 November 2019) *Progress notes in the following days demonstrate that wound care and skin assessments were completed. Bupa's expectations for monitoring and evaluation of*

wounds would be that a formal wound care plan and evaluation documentation would have been completed to support this. However, this was not done until 27 March 2019, and we sincerely apologise that this did [not] occur in a timely way. Documentation of ongoing skin and wound assessment is provided and contains adequate and appropriate information.

The InterRAI assessment (14 May–16 May 2019) and resulting care plan (20 May 2019) clearly document [Ms A's] major skin problems and need for assessments each shift. The care plan reiterates the responsibility of RNs to conduct skin assessments and instruct HCAs on the application of creams. The care plan also lists what actions need to take place to prevent pressure areas.

What is the standard of care/accepted practice?

The standard of care is that six-monthly InterRAI assessments take place and the resident's care plan is developed or updated accordingly. Skin and wounds are assessed, and this is documented each shift where a resident is at risk of rapid deterioration in skin integrity.

I am satisfied that the standard of care was met between 23 March and 31 August 2019. While there was an acknowledged delay in completing formal documentation between the 23 and 27 March I am satisfied that adequate and appropriate care was being provided.

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

I do not believe there was a departure from the standard of care.

How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

Not applicable.

8. In my opinion, were the actions taken by Bupa as detailed in its "Corrective Action Plan" to prevent a similar incident occurring in future sufficient and appropriate [The] (Clinical Service Improvements Co-ordinator) provides the following list of corrective actions put in place by BUPA:

On 4 April 2019 and 9 May 2019 — RNs were reminded of their obligations to monitor, assess, and report incidents and wounds at a staff meeting and this included reiteration on documentation expectations.

A daily skin observation chart was initiated and aimed to empower [Ms A] to keep a record of skin assessments as staff completed them.

Staff included documentation in the progress notes of assessments completed and were expected to complete additional wound assessments and care documentation in line with Bupa requirements.

On 7 May 2019 — at a general staff meeting a further reminder was provided around Riskman (Bupa's national electronic incident and infection database) utilisation, and specifically the issues identified as a result of [Ms A's] earlier complaint Environmental factors (around insect/fly control) was also assessed.

Support was sought from [a company] to complete an environmental assessment of [Ms A's] room and the greater facility. As a result, [Ms A's] room was given a deep clean and additional automatic fly spray dispensers were located at suitably identified sites throughout the care home. Housekeeping and care staff were alerted to ensure any food crumbs were cleaned up after each meal and open food packets were to be removed. Staff were provided with the RAIN model for supportive communication to utilise with [Ms A] …

What is the standard of care/accepted practice?

Accepted practice is that when a significant incident occurs requiring investigation that all aspects and contributing factors to the incident are examined and a plan put in place to prevent further recurrence of similar incidents.

In this case I am satisfied that all aspects of the incident have been addressed and an appropriate action plan has been put in place. The plan acknowledges and addresses shortcomings in reporting and documentation by caregivers and RNs. Appropriate education has been put in place. The plan also empowers [Ms A] in involving her in the documentation of skin inspections and the provision of the RAIN model for supportive communication. Concerns related to [Ms A's] environment were also addressed in an appropriate way. The plan is comprehensive, sufficient and appropriate.

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

There has been no departure from accepted practice.

How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

Not applicable.

9. The adequacy of Bupa's wound management policy

Bupa's wound management policy was provided. The policy includes detailed instructions around wound assessment and grading, pain assessment, wound healing, principles of wound management, dressing technique, wound management and care

planning and evaluation. It also refers to the monthly wound log, dressing types, management of chronic wounds and guidelines for accessing expert advice. What is the standard of care/accepted practice? The standard of care is that a wound management policy contains guidelines for the assessment, management, and evaluation of wounds. The policy should also contain standards for documentation and up to date information on dressing products and techniques. Bupa's wound management policy meets all of these requirements and is line with the guidelines and protocols produced by the New Zealand Wound Care Society.

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

There has been no departure from the standard of care.

How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

Not applicable.

16. Any other matters that I consider warrant comment.

There are no other matters I consider warrant comment.

Rachel Parmee RGON, MA (Nursing)'

'9 December 2020:

Thank you for the opportunity to provide further advice on this case, for which I provided initial advice on 26/09/2020.

In my initial advice I made the following comment:

Care sheets provided by BUPA have a section named "Pressure Area Care" which is consistently marked Y for morning and afternoon shifts. I note there is a section named "Documentation Completed" which is blank on the majority of days. This does not correspond with the progress notes. I am wondering if the care sheet is for HCAs to complete and progress notes the domain of RNs. This is significant as there does not appear to be detail of what "Pressure Area Care" entailed and whether it included skin inspection. In the investigation following the incident it was revealed that an HCA had noted redness on [Ms A's] skin, which in her case would have been a cue for reporting and further intervention from the RN. There is no written evidence that the redness was reported to the RN or acted on by the RN.

I have now been provided with further information from [the care home] about the care sheets and Pressure Area Care section. I am asked to comment on whether this changes my initial advice.

In their further advice BUPA state that they use exception reporting. In the case of [Ms A] an exception would be the redness noted on her skin by an HCA. As I have stated in my initial advice this exception was not documented as being reported to the RN or acted on by the RN.

Therefore, the further information does not alter my initial advice.

Rachel Parmee
RGON, MA (Nursing)'

Appendix B: Standards

Te Kaunihera Tapuhi o Aotearoa|Nursing Council of New Zealand Code of Conduct Guidance: Documentation

Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been.

Appendix C: Bupa's Admission Agreement

Bupa and Mr B entered into an Admission Agreement in 2015 for Ms A's care, which stated:

> '11 Changes to Care
>
> 11.1 There may be situations when the Resident's needs change, and in the reasonable opinion of Bupa Care Services those needs can no longer be met by Bupa Care Services at the Facility. In those situations Bupa Care Services will ensure that:
>
> 11.1.1 Appropriate reassessment takes place to ensure that appropriate care management protocols have been observed. This may involve the assistance of staff from the Needs Assessment and Service Co-ordination Service or the Mental Health for the Older Person's organisation to attempt to find solutions to ensure the Resident remains in the Facility;
>
> 11.1.2 Bupa Care Services will assist in the process of finding an alternative service provider if requested and it is appropriate under clause 11.1.1;
>
> 11.1.3 Any transfer from the Facility to an alternative service provider takes place in an appropriate and timely way.
>
> 13. Termination
>
> 13.1 Subject to clause 14, this agreement may be terminated and the Resident may be asked by Bupa Care Services to leave the Facility immediately:
>
> Following the expiry of 21 days' notice being given by Bupa Care Services to the Resident advising the Resident of the termination of this agreement.
>
> ...
>
> If the Facility is closed or if Bupa Care Services is unable for reasons beyond its reasonable control to provide the Services to the Resident.'