HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Aged Care Commissioner

(Case 22HDC01954)

Contents

Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner.

2. The report discusses the care provided to Mr A (aged 71 years at the time of events) at Heritage Lifecare (trading as Dunblane Lifecare).[1]

3. Sadly, in Month8 2019[2] Mr A passed away in hospital. Mr A's death was referred to the Coroner. The Coroner consulted Mr A's surgeon, who expressed concern about what appeared to be insufficient care and late escalation of care regarding the management of Mr A's pressure injury wounds on his sacrum. Mr A's family also shared the surgeon's concerns.

4. On 20 June 2022 this Office received a referral from the Coroner about the care provided to the late Mr A.

[1] Dunblane Lifecare was sold by Heritage Lifecare in June 2021 and now is owned by New Zealand Aged Care Services Ltd (but still trades as Dunblane Lifecare).
[2] Relevant months are referred to as Month1–Month8 to protect privacy.

Names (except Heritage Lifecare Limited (trading as Dunblane Lifecare) and the advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. The following issue was identified for investigation:

- *Whether Heritage Lifecare Limited (trading as Dunblane Lifecare) provided [Mr A] with an appropriate standard of care between [Month2] 2019 and [Month8] 2019 (inclusive).*

Background

6. Mr A was admitted to Dunblane Lifecare on Month1 initially for respite care,[3] as he was unable to cope at home because his house required modifications (such as access ramps). General practitioner (GP) Dr B undertook a full medical assessment of Mr A on admission. Mr A's chronic pressure injuries were not noted during this assessment.

7. Mr A's medical history included a fall off the back of a truck in 1971, which resulted in a head injury, a left brachial plexus injury,[4] left arm weakness, and left diaphragmatic paralysis.[5] His medical co-morbidities included cerebellar atrophy[6] with poor balance, right sensorineural hearing loss,[7] epilepsy, and a TURP.[8] At the time of these events, he required a wheelchair to mobilise.

8. Mr A's wife was his first contact and next of kin, with Mr A's granddaughter his second contact and the family's representative. Mr A did not have an activated Enduring Power of Attorney (EPOA)[9] or advanced care plan.[10]

9. On 14 Month3, following his respite care, Mr A became a permanent resident at Dunblane Lifecare and required rest-home-level care.

Wound management timeline Month1 to Month4

10. Dunblane Lifecare provided HDC with evidence that Mr A's Norton Scale[11] pressure area risk was completed three times.

11. However, the first Norton scale assessment on 22 Month1 assigned Mr A's physical condition as the highest rating, even though he had a pressure area, and noted that he was ambulant, when in fact he had to use a wheelchair to mobilise. The assessment also noted that he was in total control of his bladder and bowels, when actually he was doubly

[3] Respite care is short-term care provided in an aged-care facility.
[4] Brachial plexus injuries typically stem from trauma to the neck, and can cause pain, weakness, and numbness in the arm and hand.
[5] Paralysis of the diaphragm, which can lead to difficult or reduced breathing capability.
[6] Shrinkage of the brain and decline in cognitive ability.
[7] The most common type of hearing loss.
[8] A transurethral resection of the prostate (surgery to treat urinary blockage caused by an enlarged prostate).
[9] A legal document in which a person (the donor) appoints another person (the attorney) to make decisions on the donor's behalf if the donor becomes incompetent.
[10] A resident's wishes for how they would like to be cared for in the future.
[11] A tool used to evaluate a person's risk of developing a pressure injury. The person is rated from 1 (high risk) to 4 (low risk) covering five areas — physical condition, mental condition, activity, mobility, and continence. A score of 14 or less indicates that a resident is at risk of developing pressure injuries.

incontinent. The total score allocated was 18. A score of 14 or less indicates that a resident is at risk of pressure injuries, which can trigger interventions by a registered nurse.

12. On 22 Month2 Mr A informed a registered nurse that he had an 'injury by his bottom'. The nurse noted that he had broken skin and redness around his sacrum and identified this as a pressure injury.[12] The nurse notified the clinical nurse manager and commenced paperwork, which included:

- A short-term care plan, the goal of which was to 'promote healing and minimise infection/further complications'. The interventions included applying dressings to Mr A's sacral pressure injury every third day 'as per wound care chart', and for caregivers to report to the registered nurse if the wound deteriorated. On 6 Month4, a further entry in the care plan noted that Mr A had pressure injuries in two separate areas, and on 29 Month4 it was noted that the pressure injury appeared to be healing.
- A Wound Management Plan, which noted that Mr A had a pressure injury on his sacrum, the goal of which was for Mr A's wound to heal without complication, and to clean and dress the wound every three to four days.
- Recording of Mr A's pressure injury on a Pressure Ulcer Grade Recording chart; however, the registered nurse did not specify the stage/grade[13] of his pressure injury on this date.

13. On 28 Month2 Mr A's granddaughter was informed about Mr A's sacral pressure injury. She asked whether rehabilitation could be organised to help Mr A to stay off his sacrum.

14. On 14 Month3, when Mr A was accepted for permanent placement in rest-home-level care (following his respite care), a registered nurse completed an initial interRAI[14] assessment and care plan for Mr A. This document notes that Mr A had a '[g]rade 1' pressure injury and that he was on a wound management plan.

15. On 1 Month4 it was noted on Mr A's pressure ulcer grade chart that his pressure injury had now developed into a grade 3[15] pressure injury on the 'posterior sacrum [left] side'. Mr A's pressure ulcer grade chart contains only two entries — the first on 22 Month2 (which did not note the pressure injury stage), and the second on 1 Month4 as noted above.

16. On 11 Month4 Mr A had a second Norton scale assessment, which assigned him a score of 17, even though he needed to use a wheelchair, and he had a pressure injury.

[12] An injury to the skin and underlying tissue resulting from prolonged pressure on the skin.
[13] A pressure injury is graded from 1 to 5 to specify the level of tissue damage the person has experienced. For example, a grade/stage 1 pressure injury could be described as redness of the skin and a closed wound, whereas a grade/stage 4 pressure injury is an open wound that extends to the muscle, tendon or bone.
[14] A mandatory primary assessment tool for long-term residential aged care in New Zealand. It is used to assess a resident's needs and inform the resident's care plans.
[15] A grade 3 pressure injury extends through the person's skin into deeper tissue and fat but does not reach muscle, tendon or bone.

Hospital admissions Month5 to Month6

17. In Month5 and Month6 Mr A was admitted to hospital as his health had deteriorated.

18. On 12 Month5 Mr A was admitted to hospital following a fall. Medical notes document that he had been found in his room with a high temperature and respiratory rate and that his room smelled of 'infected type' urine. Mr A told the hospital Emergency Department team that he did not fall, but rather the brakes on his wheelchair were not on, and he had slid to the ground. He was diagnosed with plural effusion, a chest infection, and a urinary tract infection (UTI). Mr A was discharged back to Dunblane Lifecare on 17 Month5.

19. At 6.41pm on 16 Month6 Mr A was re-admitted to hospital with bilateral leg swelling. He was diagnosed with acute kidney injury likely due to urinary outflow obstruction.

Wound management timeline Month6 to Month8

20. On 10 Month6 the third and last Norton scale assessment assigned Mr A a score of 17. On 1 Month7 a new short-term care plan was commenced for Mr A's grade 3 pressure injury on his sacrum. The goal was to 'promote heal and minimise infection' and to check Mr A 'daily' for pain or any sign of infection, take a 'weekly photo', and arrange a referral to a wound care specialist nurse for guidance if needed. This care plan contains two entries, one on 7 Month7 regarding reviewing the dressings, and the other on 13 Month7 regarding the wound dressing being renewed.

21. On 11 Month7 a clinical nurse specialist in wound care who was based in the community reviewed Mr A's pressure injury.

22. On 1 Month8 the clinical nurse received another referral and reviewed Mr A's pressure injury on 3 Month8. She noted issues such as a sheepskin on top of the pressure-relieving mattress and suggested positioning Mr A appropriately to offload the sacral area. She also suggested seeking input from a dietitian. She discussed Mr A's case with a general surgeon, who organised a debridement[16] of Mr A's pressure injury wound.

23. On 3 Month8 Dunblane Lifecare informed Mr A's wife that Mr A would be going to hospital for a debridement of his pressure injury wound.

24. On 4 Month8 Dunblane Lifecare emailed a needs assessor requesting a review of Mr A for hospital-level care. The needs assessor said that Mr A's needs had increased due to his pressure injury debridement, an increase in the number of falls he was having, and his need to use the standing hoist for all transfers.

Hospital admission 5 Month8

25. On 5 Month8 Mr A underwent a 'debridement of necrotic[17] sacral pressure ulcer' performed by Dr C. The operation report notes that Mr A's pressure injury had '[d]eeply … necrotic

[16] Removal of dead or infected skin tissue to help a wound heal.
[17] Dead tissue.

tissue extended to the sacrum and there was evidence of osteomyelitis[18] as parts of sacral bone easily came away upon pressure'. Mr A was found to be suffering from sepsis[19] and was admitted to intensive care following the surgery.

26. The hospital progress notes on 8 Month8 document that Mr A's family were informed by Dr C that Mr A was likely for 'palliative[20] wound management [and] has 80–90% chance of not coming out of hospital'.

27. Sadly, in Month8 Mr A passed away in hospital. The Coroner took jurisdiction after Dr C expressed concerns around the circumstances leading to Mr A's admission for pressure injury surgery and his subsequent death. The family agreed to the Coroner taking jurisdiction.

28. In a letter to the Coroner's office, Dr C noted that Mr A's death 'may have been avoided if his wounds had been treated earlier'. Dr C also noted that Mr A's behaviour made it difficult for staff to encourage him to cooperate, which 'may have contributed to difficulty in regularly assessing the pressure ulcer'.

29. On 15 Month8, HealthCERT was informed of Mr A's stage 4 pressure injury.

Mr A's wound charts

30. Wound charts for Mr A's pressure injury were maintained over four months from 1 Month4 to 7 Month8 and a summary is included as Appendix B. The table includes information about the size and depth of the pressure injury over this time, whether there was exudate[21] that required more frequent dressing changes, whether Mr A expressed pain related to his wound, when his discomfort was noted on the pain scale,[22] and when photos of the wound were taken.

31. The wound charts contain 26 entries. I note the following:

- Mr A's wound became larger and deeper as the days progressed.
- Out of the 26 entries, only two entries noted 'no exudate' from the wound.
- Out of the 26 entries, 13 entries noted that Mr A complained of pain. It was further noted that from 30 Month7 to 7 Month8 he complained of pain every day, with his pain scale increasing from 4/10 initially on 30 Month7, to 8/10 on 7 Month8.
- Out of the 26 entries, only six photos were taken to document Mr A's wound over the four months.

[18] Infection in a bone.
[19] A serious condition in which the body's response to an infection causes injury to its own tissue and organs.
[20] Relieving the symptoms of an incurable medical condition.
[21] Fluid leaking from a wound.
[22] A pain assessment tool with a scale numbered from 0 (no pain) to 10 (the worst possible pain). As pain is subjective to the person, the person will be asked to rank their pain from 0–10. The number is recorded and used to guide pain-relief interventions.

Pressure injury as noted in progress notes table

32. Entries in Mr A's progress notes that mention his pressure injury wound and treatment (such as applying a new dressing) is included as Appendix C. The table also notes when Mr A's GP or his family were contacted regarding his pressure injury. These details are discussed later in this report.

33. Mr A's pressure injury wound entries were tracked over six months from 3 Month2 to 7 Month8. As reflected in the table, 63 entries mentioned Mr A's pressure injury wound and its management:

- From 14 Month4 the wound was noted to be 'very smelly' and Mr A needed two carers to help the registered nurse to apply his wound dressings.
- On 19 Month4, as documented in the progress notes, a registered nurse expressed her concerns to the nursing manager that Mr A needed two carers to assist her when changing his wound dressing, showering, and transferring. She suggested that Mr A's level of care be reassessed as currently he was in rest-home-level care, but he needed more help from staff.

Communication between Dunblane Lifecare and GP

34. Dr B was approached by the Coroner regarding his involvement in Mr A's case and his recollections. Dr B was asked whether he was aware that from Month2 Mr A was suffering from unresolved pressure wounds to the sacrum. Dr B responded that he was not aware of Mr A's pressure wounds. He stated that the first mention of the pressure injuries he saw in Mr A's records was in Mr A's ED attendance on 7 Month8 and on the discharge summary after Mr A died on 17 Month8. Dr B noted that Mr A had been in hospital twice before this, from 12–17 Month5 and from 16–24 Month6 but the pressure injuries were not mentioned in those discharge summaries.

35. Dr B was asked whether at any stage he examined Mr A's pressure injuries, to which he answered no, as 'they were not brought to [his] attention and [he] was unaware of their presence'. Dr B stated that he had an understanding/agreement with Dunblane Lifecare's resident GP that they would assess his patients if there were problems that needed seeing to, otherwise he would see his patients after work, and usually visit them every three months as a routine check-up. Dr B said that if he received a fax from Dunblane Lifecare regarding advice for an acute problem or check-up, he would attend in person. He stated: 'I did not have any requests from Dunblane regarding pressure sores.'

36. A table summarising when Mr A's care was escalated to his GP is included as Appendix C. The table covers six months from 3 Month2 to 7 Month8 and includes information about when the GP was informed of medical issues relating to Mr A.

37. As reflected in the table, during the six months from 3 Month2 to 7 Month8, the following was noted:

- Mr A's care was escalated to the GP twice — first on 10 Month6 regarding Mr A's oedematous feet, and secondly on 15 Month6 regarding Mr A's urine specimen.
- Mr A's GP was at no time informed of Mr A's pressure injury wound.

Communication between Dunblane Lifecare and family

38. Mr A's granddaughter told Police that her name was on Dunblane Lifecare's record as the main family representative. She noted that she 'raised concerns regarding [Mr A's] care several times'. She stated that when Mr A was transferred to hospital on 7 Month8 she was not notified, and instead Mr A's wife was notified. She said that she was shown a photo of Mr A's pressure injury and was told by the ED doctor that '[it] was already too far gone'. She said that Dunblane Lifecare never gave her any information about Mr A's pressure injury while he was a resident and stated: 'I just can't believe that nobody at Dunblane noticed the severity of the pressure sore as my Grandfather needed to be assisted to bed, in the shower and everything.'

39. A table summarising when Mr A's family were contacted by Dunblane Lifecare is included as Appendix C. The table covers six months from 3 Month2 to 7 Month8 and includes information on when Dunblane Lifecare contacted Mr A's family and vice versa, the subject of the discussions, when they visited Mr A, and where these visits or discussions were noted (that is, on Dunblane Lifecare's family/whānau communications record sheet or in Mr A's progress notes).

40. The following is noted:

- Mr A's family were contacted by Dunblane Lifecare 31 times.
- Family visited Mr A 11 times.
- Only twice were the family notified of Mr A's pressure injury — first, on 28 Month2 when Mr A' granddaughter was informed that Mr A had a pressure injury on his sacrum, and, secondly, on 3 Month8 when Mr A's wife was told that Mr A needed to go to hospital on 9 or 10 Month8 for debridement of his pressure injury wound.

41. In response to the provisional opinion, Heritage Lifecare considered that as Mr A was mentally competent, there was no requirement to advise his family of his care.

interRAI assessments

42. On 14 Month3 Mr A became a permanent resident at Dunblane Lifecare in rest-home-level care.

43. Mr A's initial interRAI noted that he had a 'grade 1' pressure injury. It also noted that Mr A required a wheelchair to mobilise safely, due to his poor mobility and balance and a fear of falling, and that in terms of his pressure ulcer there was an 'increased risk of [the] pressure injury [worsening] related to [being] wheelchair bound'. Mr A needed assistance with showering and to dress, and he was doubly incontinent. The interRAI also noted that Mr A would be seen by the GP three monthly or as clinically indicated.

44. The interRAI assessment noted that Mr A's decision-making ability was decreased, and often he would make unsafe decisions, and he was unwilling to listen to staff advice. It noted that Mr A understood conversations and liked to be told what was happening, and that he was 'increasingly angry and aggressive to staff … [and] verbally abusive'. The interRAI also noted that at times it was obvious that he was in pain but he refused to take pain medication and would spit it out.

45. On 1 Month8 Mr A's interRAI was reassessed because of his gradual deterioration since returning from hospital on 24 Month6, and on 4 Month8 it was confirmed that Mr A had been assessed as needing hospital-level care.

46. Mr A's interRAI was completed by nursing staff at Dunblane Lifecare.

47. In response to the provisional opinion, Heritage Lifecare told HDC:

> '[Mr A] underwent an assessment by a Needs Assessment Service Co-ordinator independent of Heritage on 19 [Month3]. The provisional decision is critical of Dunblane in terms of its assessment of [Mr A] at rest home level care, however this assessment was made by an independent Needs Assessment Service.'

Further information

48. The Coroner's office wrote to Heritage Lifecare for comment regarding its management of Mr A. In a letter from Heritage Lifecare to the Coroner on 19 Month5, Heritage Lifecare stated that there was a 'delay' between when the pressure area on Mr A's sacral area was first noticed on 4 Month2, and a care plan was started on 22 Month2.

49. Heritage Lifecare noted that it appeared that Mr A's pressure injury 'had deteriorated between [Month2] and [Month5], and this could be due to less than adequate wound care'. Heritage Lifecare stated that Mr A had 'particular routines' such as choosing to sit for prolonged periods in his wheelchair, and it was reported that he would become aggressive towards staff if they tried to alter his routine. Heritage Lifecare also noted that Mr A had faecal incontinence, and that the combination of these challenging features meant that 'even with the best care provided the pressure injury could still have deteriorated'.

50. In response to the provisional opinion, Heritage Lifecare told HDC:

> '[D]ecisions have been made based on the documentation, without Heritage having the ability to actually speak with the staff who were involved … Of particular relevance is the difficulty that appears to have been experienced by staff in caring for [Mr A] given his aggressiveness and abusiveness to staff when he had different views on what should occur around his care.'

51. On 11 Month7 a clinical nurse specialist reviewed Mr A and suggested the use of a pressure-relieving mattress. Heritage Lifecare stated that the pressure-relieving mattress was put in place on 15 Month7. Heritage Lifecare noted that Mr A 'suffered a gradual deterioration in his condition throughout his time at Dunblane [and coincidentally] with this deterioration,

his pressure injuries seemed to deteriorate again'. A photograph of Mr A's pressure injury taken on 1 Month8 showed that it had 'deteriorated significantly', and this prompted staff to request a clinical nurse wound specialist review.

52. The clinical nurse specialist reviewed Mr A on 3 Month8 and arranged an admission to hospital for debridement of the pressure wounds on his sacrum. Heritage Lifecare said that daily dressings were performed from 1 Month8, but on 7 Month8 Mr A deteriorated and was admitted to hospital and did not return to Dunblane Lifecare. Heritage Lifecare stated that there could have been better documentation, 'particularly around the wound care plans', but said that it is unclear whether this would have prevented the ongoing deterioration of the wound.

53. When asked why Mr A's GP was not asked to review Mr A's pressure wounds at any stage, Heritage Lifecare said that in its opinion, '[a] wound care specialist [clinical nurse specialist] would … be of more value in effectively treating pressure injuries than a GP would'. The Coroner also asked why there was no escalation of care for Mr A's pressure wounds to a GP or hospital before 7 Month8. Heritage Lifecare stated that there was escalation when a clinical nurse specialist was asked to review Mr A on 1 Month8 and reviewed the wound on 3 Month8 and then organised a surgical debridement of his wound.

54. In response to the provisional opinion, Heritage Lifecare told HDC:

> 'It is not apparent that your Office has actually investigated the care of [Mr A's] pressure injury while he was a resident in [the public] hospital. In order for a comprehensive investigation, that should have occurred.'

Responses to provisional opinion

New Zealand Aged Care Services Limited (recent owners of Dunblane)

55. New Zealand Aged Care Services Limited was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations, and its comments have been incorporated into this report where relevant.

56. New Zealand Aged Care Services Limited accepted the Aged Care Commissioner's opinion but noted:

> '[T]hese events occurred with Heritage Lifecare while trading as Dunblane Lifecare. This Care Home has since been sold by Heritage Lifecare and now operates under different management and leadership, policies and processes, and nursing staff.'

Mrs A

57. Mrs A was given the opportunity to respond to the 'information gathered' section of the provisional opinion, but HDC did not receive a response.

Heritage Lifecare

58. Heritage Lifecare was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. Its comments have been incorporated into this report where relevant and have been addressed in separate correspondence.

Opinion: Dunblane Lifecare — breach

59. First, I acknowledge the distress these events have caused Mr A's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Heritage Lifecare (trading as Dunblane Lifecare) was appropriate, I considered in-house clinical advice from Nurse Practitioner (NP) Isabella Wright (Appendix A).

Pressure injury wound management

60. NP Wright advised that the calculations made to assess Mr A's pressure wound on the Norton scale were an 'inaccurate assessment' of his needs, particularly in the areas of mobility (where in fact he required a wheelchair), skin integrity (where in fact it was compromised due to his pressure injuries), and continence (where in fact he was incontinent). NP Wright advised that '[i]f accurate assessment of the Norton Scale [had been] completed — this might have increased the risk of [pressure injuries] and triggered increased input from [registered nurses]'.

61. NP Wright noted that Mr A's sacral pressure injuries were not checked daily until later in Month7, and although weekly wound photos were required to monitor Mr A's pressure injury, only six photos were taken.

62. NP Wright noted that the wound care plans stipulated only 'basic' management such as a saline clean and foam dressings. She considered that more 'effective selection of dressings' could have been more appropriate to allow, for example, chemical debridement of the wound'.

63. NP Wright advised that the lack of accurate assessment of Mr A's pressure injury risk (via the Norton scale), the lack of referral of the wound to the GP, the slow escalation to the wound clinical nurse specialist, and the 'inadequate wound management plan', all constituted a moderate to severe departure from the accepted standards of care.

64. I accept NP Wright's advice. It is concerning that Mr A's pressure injury risk was assessed inaccurately, and therefore led to a score that would not have triggered nursing staff to escalate his care to the wider team.

65. I am critical that Mr A's GP was not informed of Mr A's pressure injuries. I acknowledge Heritage Lifecare's statement that a wound care specialist would be of more value than a GP in treating the pressure injuries effectively. However, I note that it was not until Month7 that a referral was made to the wound care nurse, which was far too late, given that staff had been aware of the pressure injury since Month2. Had staff informed Dr B about Mr A's

pressure injury in Month2, Dr B could have helped to co-ordinate the wound management care.

66. In its response to the provisional opinion, Heritage Lifecare stated that HDC should have investigated the wound care management when Mr A was in the public hospital. NP Wright noted that the documented evidence about the pressure injury/wound management is clear, and therefore she remains of the view that Mr A's pressure wound management by Dunblane Lifecare was inadequate. It is noted that Mr A was admitted to hospital only twice between Month1 and Month8, and therefore I believe it was appropriate to investigate Dunblane Lifecare, as he was there for the majority of the time.

67. I note that Heritage Lifecare stated that Mr A had 'particular routines' such as sitting for long periods in his wheelchair. Whilst I agree that it is likely that this contributed to the breakdown of Mr A's pressure injury, I also note that in Month2 Mr A's granddaughter had asked staff to implement rehabilitation to help Mr A stay off his sacrum. I am critical that the multi-disciplinary team (including physiotherapists, occupational therapists, and Mr A's GP) were not involved immediately to help Mr A stay off his sacrum as much as possible.

68. In addition, in its response to the provisional opinion, Heritage Lifecare was concerned that Mr A's aggressiveness and abusiveness to staff made it difficult for his pressure injury to be checked. The documentation obtained did not provide sufficient evidence to support that Mr A was aggressive to the extent that it affected the care provided. The clinical records indicate only three instances where Mr A was resistant to cares and aggressive to carers, and the other entries refer to him being cooperative and pleasant. I believe it is appropriate to rely on what was documented, which indicates that Mr A was cooperative and pleasant.

69. Heritage Lifecare noted in its response that there could have been better documentation, 'particularly around the wound care plans' but said that it was unclear whether this would have prevented the ongoing deterioration of the wound. While I agree that documentation could have been improved, I consider that an early co-ordinated multi-disciplinary approach to managing Mr A's wounds may have prevented the deterioration that occurred over the seven months Mr A was a resident at Dunblane Lifecare.

Communication between Dunblane Lifecare and GP

70. Dr B stated that Mr A's pressure injury wounds were 'not brought to [his] attention and [he] was unaware of their presence'. He said that had he received a request for a check-up from Dunblane Lifecare staff, he would have attended in person, but he 'did not have any requests from Dunblane regarding pressure sores'. Dr B stated that it was only on 17 Month8, after Mr A passed away, that he was made aware of Mr A's pressure injury wounds.

71. A table summarising when Mr A's care was escalated to his GP is included as Appendix C. As reflected in the table, during the six months from 3 Month2 to 7 Month8, at no time was Dr B informed of Mr A's pressure injury wounds.

72. NP Wright noted:

> 'The management of pressure injuries requires that high-risk people (such as [Mr A]) are identified, and [pressure injury] management plans are developed in collaboration with [the multi-disciplinary team]. The delay in referrals to [the] GP … have likely contributed to further decline in [Mr A's] sacral pressure injuries.'

73. NP Wright considered that the lack of communication from Dunblane Lifecare staff to Mr A's GP in relation to his deteriorating pressure injury wounds was a moderate to severe departure from accepted standards of care. I accept NP Wright's advice. As she noted, for a resident to get the best medical care, and particularly where a patient has complex medical needs, a multi-disciplinary approach with input not only from nursing staff, but also from the GP, physiotherapist, dietitian, etc is required. I am critical that staff did not inform Mr A's GP about his deteriorating pressure injury. There is evidence in Mr A's progress notes, and the associated wound care management tools set up (such as the short-term care plans) that staff at Dunblane Lifecare were aware of his pressure injuries, but did not involve Dr B. This is unacceptable. Had Dr B been made aware of Mr A's pressure injuries, a more co-ordinated multi-disciplinary approach to managing these injuries would have occurred and possibly surgery could have been avoided for Mr A.

Communication between Dunblane Lifecare and Mr A's family

74. Mr A's granddaughter stated to Police that she had 'raised concerns' about Mr A's care several times to Dunblane Lifecare staff and that the family were not informed about the severity of Mr A's pressure injury. The first time the family were made aware of the severity of the pressure injury was on 7 Month8 when an ED doctor showed the family a photo of Mr A's pressure injury and told them that '[it] was already too far gone'. Mr A's granddaughter stated: 'I just can't believe that nobody at Dunblane noticed the severity of the pressure injury as my Grandfather needed to be assisted to bed, in the shower and everything.'

75. Mr A's clinical records show that the family were notified of Mr A's pressure injury on only two occasions, on 28 Month2 and 3 Month8.

76. NP Wright considered that the communication between Dunblane Lifecare and the family amounted to a moderate departure from the accepted standards of care. I accept NP Wright's advice and share Mr A's granddaughter's concern that the family were not informed of Mr A's deteriorating pressure injury, considering that he required assistance by two carers in the shower, and therefore they would have been able to see the pressure area wound on his sacrum.

77. Whilst I acknowledge Heritage Lifecare's comment that as Mr A was competent, and there was no requirement to advise his family of his care, according to the clinical records, Mr A's family were often involved in his care as they visited regularly. There was an understanding that they would be updated, particularly about a deteriorating wound, given the precedent

set where previously they had received communications from the care home about changes in Mr A's condition.

78. I find it unacceptable that during Mr A's stay at Dunblane Lifecare from Month2 to Month8, the family were notified about his pressure injuries only twice. This is despite the progress notes showing multiple entries from nursing staff regarding Mr A's pressure injury and the established wound-care charts and short-term care plans that were in place to manage it. I consider that the communication between Dunblane Lifecare staff and Mr A's family regarding his pressure injury was inadequate, and I am critical that the family were not informed about the condition of his wounds regularly.

interRAI assessments

79. Mr A's interRAI completed in Month3 assessed that he needed rest-home-level care. However, his interRAI assessment noted that Mr A required a wheelchair to mobilise, his decision-making ability was decreased, and often he would make unsafe decisions. Mr A was noted to require assistance with showering and dressing and was doubly incontinent. NP Wright considered that Mr A's interRAI assessment 'may not have been completed appropriately'. NP Wright advised:

> 'The concern is that a resident who is paraplegic, immobile, with double-incontinence and requiring high level of assistance with [activities of daily living] from staff is assessed to be suitable for rest home level of care. The more appropriate care level would seem to be of hospital level of care.'

80. NP Wright noted that if Mr A had been assessed at a higher level of care, such as hospital level, this would have ensured monthly GP reviews.

81. On 1 Month8, Mr A's interRAI was reassessed because of his gradual deterioration since returning from hospital in Month6, and on 4 Month8 it was confirmed that Mr A needed hospital-level care.

82. NP Wright noted that Mr A deteriorated between Month3 and Month6, and therefore the reassessment of his level of care in Month8 was not completed in a timely manner.

83. NP Wright stated:

> '[I]t was unclear from the documented evidence about who completed the first interRAI assessment prior to [Month3] — most likely to have been [a] Needs Assessor in the public hospital. The care home had the ability to question the level of care on admission.'

84. NP Wright advised that this constituted a mild departure from accepted practice.

85. I accept NP Wright's advice. I agree that Mr A was not assessed for the appropriate level of care considering his complex medical needs, particularly as he required assistance with showering and dressing and required a wheelchair to mobilise. It is also documented that

Mr A required two carers to support him while the registered nurse changed his sacral pressure injury wounds, and he needed assistance to keep this area clean when he was incontinent. It is also recorded that at times Mr A was resistive to cares, so the requirement of extra support by two carers was reasonable. It is further documented that Mr A appeared to deteriorate and needed to go to hospital twice, but this still did not trigger staff to consider that he required another interRAI assessment until Month8. I am concerned that although staff witnessed Mr A's deterioration, particularly after his hospital stays in Month5 and Month6, this did not trigger another interRAI assessment sooner. It is apparent that staff at Dunblane Lifecare lacked understanding on how to assess deteriorating residents appropriately, and I consider that it is Dunblane Lifecare's responsibility to offer the resources and training to support staff in this area.

Medical oversight from GP

86. Mr A was admitted to hospital in Month5 and Month6 when his health deteriorated. Regarding his pressure injuries, NP Wright noted that there was 'no evidence that the rest home engaged the GP in overview of [Mr A's] pressure injury … [therefore the minimal] GP oversight was acceptable in the circumstances'.

87. As noted above, at no time between 3 Month2 and 7 Month8 was GP Dr B informed of Mr A's pressure injury wounds.

88. NP Wright found no departure from accepted standards of care regarding GP oversight of Mr A. I accept NP Wright's advice. For Dr B to review Mr A, he first had to be informed of the issue, but it is clear from the evidence that he was not, despite the progress notes during this six-month period showing multiple entries from the nursing staff regarding the management of Mr A's pressure injuries and his deterioration. In my opinion, it is not from lack of care that the GP did not review Mr A's pressure injuries, but due to not being informed of them. As such, I am not critical of Dr B's oversight of Mr A's care.

Three-monthly medical reviews

89. On 9 Month4 Mr A had his first interRAI assessment and was assessed as requiring rest-home-level care. At this level of care, Mr A would have been seen by the GP three-monthly or as clinically indicated.

90. NP Wright considered that three-monthly reviews 'were appropriate for the level of assessed care for [Mr A]', and as such, found no departure from expected standards of care.

91. I accept NP Wright's advice. For Mr A to receive monthly reviews, he would have had to be assessed as requiring a higher level of care, such as hospital-level care. Three-monthly reviews for residents at rest-home-level care are considered appropriate.

Conclusion

92. In summary, I find that Heritage Lifecare (trading as Dunblane Lifecare) did not provide Mr A with an appropriate standard of care between Month2 and Month8 (inclusive), for the following reasons:

a) Mr A's pressure injury wound deterioration showed a pattern of suboptimal care and a lack of escalation to appropriate multi-disciplinary team members.

b) At no time was Mr A's pressure injury wound care escalated to Dr B, even though the wound was deteriorating.

c) During Mr A's stay at Dunblane Lifecare, only twice were the family informed of his pressure injuries. The first time was when the injuries were first discovered in Month2, and the second time was in Month8 when Mr A had to go to hospital for surgical debridement because of deterioration of the wound.

d) Mr A should have been assessed as needing hospital-level care, but instead he was assessed as needing rest-home level care. This was not appropriate given his complex medical needs, which meant that he required additional support.

93. Accordingly, I consider that Heritage Lifecare (trading as Dunblane Lifecare) breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[23]

Recommendations

94. I recommend that Dunblane Lifecare undertake the following, within three months of the date of this report:

a) Review the education/training being provided to staff in relation to interRAI assessment and care planning and ensure that these processes align with accepted practice and guidelines; Dunblane Lifecare is to provide HDC with evidence of the education/training in the form of education/training material.

b) Review the education/training being provided to staff in relation to wound management and assessment of pressure injuries, the Norton scale, and the importance of timely referrals to the multi-disciplinary team, and ensure that it aligns with accepted practice and standards; utilise the Frailty Care Guidelines and wound nurse experts or a wound care champion for the training programme; and provide HDC with evidence of the education/training in the form of education/training material.

c) Review the education/training being provided to staff in relation to communication with a resident's family, and the importance of this communication being timely and appropriate and ensure that it aligns with accepted practice and standards; and provide HDC with evidence of the education/training in the form of education/training material.

d) Ensure that staff complete HDC's Code of Rights online training modules[24] and provide HDC with evidence that this has occurred.

[23] Right 4(1) stipulates that '[e]very consumer has the right to have services provided with reasonable care and skill'.

[24] Health and Disability Commissioner (2023). Online Learning: https://www.hdc.org.nz/education/online-learning/.

95. I recommend that Heritage Lifecare Limited (formerly trading as Dunblane Lifecare) provide a written apology to Mr A's family for the issues identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

96. In response to the provisional opinion, New Zealand Aged Care Services told HDC that Dunblane was sold by Heritage and now operates under its management, with different leadership, policies, processes, and nursing staff. It questioned whether it was appropriate for New Zealand Aged Care Services staff to complete the recommendations above, as 'these persons were not responsible for delivering care to [Mr A] while he resided there'. I considered its response and, whilst the staff and management may be different, I believe that by fulfilling the recommendations there is an opportunity for Dunblane as a facility to ensure that it is delivering good, consistent care in the areas identified above.

Follow-up actions

97. A copy of this report with details identifying the parties removed, except the advisor on this case and Heritage Lifecare Limited (trading as Dunblane Lifecare), will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from NP Isabella Wright:

'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by the Dunblane Lifecare care 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.

Documents reviewed

- All clinical documentation provided by Dunblane Lifecare, [the public] hospital and the Health Centre. Specifically:
- Clinical notes (nursing, care staff and medical) from [Month1]–[Month8]
- Wound assessment plans — 1 [Month4]–7 [Month8]
- Wound photographs — 1 [Month5]–2[Month8]
- InteRAI assessments — [Month3] and [Month8]
- Certification Audit reports — 7/1/2021 and 26/7/2022

Complaint

Complaint received by HDC from the Coroner concerning care provided by Dunblane Lifecare home to [Mr A] who died in 2019 in [the public hospital]. Complaint was reviewed by the aged care navigator on 24/4/23 and updated on 8/6/23 following receipt of additional information from the provider.

Review of clinical records

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

Clinical advice

<u>Background: (as per Aged Care Navigator's report)</u>
[Mr A] was a 72-year-old … gentleman initially admitted to Dunblane Lifecare for emergency respite care 21 [Month1], and transferred to permanent rest home level care from the 14 [Month3].

In 1971, [Mr A] had a fall from the back of a truck suffering left diaphragmatic paraplegia along with a traumatic brain injury at the time. Other medical co-morbidities included epilepsy, cerebral atrophy (likely alcohol related), right sensorineural hearing loss, left brachial plexus injury; history of a TURP and SPC insertion 2007. He was wheelchair bound at the time of the event.

Prior to admission [Mr A] resided with his wife in a residential home and was known to have a chronic stage 1 pressure injury (longstanding). Following respite admission, he was first noted by staff to have pressure injuries in [Month2] indicating a delay in assessments, and these are said to have been monitored by rest home staff throughout, however it is not evidenced as to the frequency of this in [Month2] through [Month6]. Some wound management is evident from [Month6], but no care plans or other documentation is available.

[Mr A] had monthly admissions for various issues [Month5] (pneumonia and constipation); [Month6] (urinary retention and outflow obstruction); and then began to decline towards the end of [Month7] early [Month8] at which time he was identified as having severely deteriorated wound late [Month7], referred for further wound specialist oversight subsequently seen on the 3 [Month8], and readmitted to hospital on the 7th due to acute decline and unwellness. He was further diagnosed with sepsis, cellulitis, and required extensive surgical debridement of the stage 4 infected pressure injury to the sacrum.

[Mr A] was admitted to ICU due to his complicated underlying conditions and treated with intensive IV antibiotics. His CRP appeared to improve indicating response to antibiotics, however during surgery it was clear he had osteomyelitis in the sacral bone, and extensive infection. Over the 2 weeks following surgical debridement he did not continue to thrive and, on the 16 [Month8], declined considerably. Pain was a major factor at this time, and he passed away on [Month8] 2019. During his residential admission he frequently refused pain relief.

[Mr A's] death was referred to the Coroner who consulted the surgeon regarding whether the severity of the wounds could have been prevented. The surgeon confirmed in his statement to the Coroner that he felt there was a lack of nursing oversight and escalation, hence it may have been preventable, however there was evidence of obstructive and resistive behaviour towards best practice in relation to pressure care and wound management.

Questions:

Consideration of whether medical oversight of [Mr A's] complex medical needs was in line with accepted standard; given underlying conditions?

Review of documentation indicates minimal GP involvement between the admission visit in [Month3] and [Month6], despite hospital admissions and return to facility. GP and rest home communication on 10 [Month4], 5 [Month6], 13 [Month6], 16 [Month6] does not contain any discussion or concerns about sacral pressure injury.

GP notes include ED message from [the public hospital] for admission from 12–17th [Month5] for pneumonia and constipation. Nil mention of sacral pressure injury. GP record of discharge from [the hospital] for admission from 16th until 24th [Month6] for AKI and IDC insertion, does not contain any information about sacral pressure injury.

GP record of discharge summary from [the public] hospital on 7th [Month8] states that sacral pressure injury was documented in the [Month5] discharge letter.

Note: There is a discrepancy between GP discharge summary (without documented PI) and [the public] hospital discharge summary on 16 [Month6] (with documented PI).

From the evidence reviewed to respond to this question it appears the GP was not informed of the sacral pressure injury and its deterioration. There is no evidence that the rest home engaged GP in overview of pressure injury between [Month3] and [Month6] 2019. GP oversight was acceptable in the circumstances and would be viewed similarly by my peers. **Departure from accepted practice: Nil**

Whether it was appropriate to maintain 3 monthly reviews as cited on admission for [Mr A]?

[Mr A] was admitted to rest home level of care from 14th [Month3], which validates the requirement of 3-monthly reviews by the GP.

The concern is that a resident who is a paraplegic, immobile, with double-incontinence and requiring high level of assistance with ADLs from staff is assessed to be suitable for rest home level of care. The more appropriate care level would seem to be of private hospital level of care. The higher level of care would have ensured monthly GP reviews for a resident with complex medical conditions and nursing needs. The InterRAI assessment process may not have been completed appropriately.

From the evidence reviewed to respond to this question it appears 3-monthly reviews were appropriate for the level of assessed care for [Mr A]. There is a question about the correct assessment of [Mr A's] level of care. The scheduled reviews were acceptable in the circumstances and would be viewed similarly by my peers. **Departure from accepted practice: Nil**

Consideration of the wound management oversight throughout the respite and permanent admission period to be in line with best practice and aligned with accepted nursing practice; and whether nursing staff have adequately ensured interventions were appropriate and timely to treat and prevent decline? Whether referral to the wound specialist occurred within acceptable timeframes?

4 [Month2] — Respite admission — documented 2 x broken areas on sacrum. Recorded in progress notes not recorded as incident, pressure injury recording chart does not indicate identification (22 [Month2] is first record).

12 [Month2] — progress notes indicate 'sore on bottom healing'.

22 [Month2] — further documentation of broken skin on sacrum — RN documentation Wound Management Plan and Short-term Care Plan commenced; incident form was completed. Pain assessment completed. Inconsistent review of Short-Term Care Plan

for the sacral pressure injury, however regular Norton PI Assessment was completed. (See comments later regarding Norton Scale PI Risk assessments.)

[Month4]–[Month6] — There is no evidence to suggest consistent wound assessment of this PI during this period. Progress notes indicate broken sacrum 18 **[Month3]**; 24 **[Month3]**; and 26 **[Month4]** evidence of RN oversight of breakdown to Stage 2/3 PI with photo taken — not evidenced in documentation until 1 **[Month4]**.

Wound evidenced it was initially reviewed monthly on Wound Assessment plan; however, progress notes evidence ongoing degradation of wound through **[Month4]** — slough, exudate no advice to GP or referral to Wound Care CNS.

Evidence during this period of resident's frustration and causing verbally aggressive behaviour.

13 [Month6] — Wound assessment plan — RN noted a decline in sacral PI and questioned the need to refer to Wound Care CNS, which did not happen until **[Month7]**.

27 [Month6] — Wound photograph — visible deep sacral PI with slough and necrotic tissue present.

11 [Month7] — There is evidence of Wound Care CNS input, however it would appear they may have been familiar with these wounds prior, no further documentation was provided.

15 [Month7] — Wound Care CNS recommendations implemented such as air mattress. Kylie and sheepskin were to be removed, but resident was reluctant to change this.

PI confirmed in **[Month8]** InterRAI as [Month7] consult — no mention in **[Month3]** InterRAI.

Sacral PIs declined in **[Month5]** returning to 90% slough. Necrosis evident in **[Month6]**, deteriorating through **[Month7]** and **[Month8]** consistent with CNS oversight. Photographs evidence reasonable management early [Month5] consistent with the wound assessments.

4 [Month8] — CNS input — referred to Dietician and for surgical debridement of sacral PIs.

7 [Month8] — admitted to [public hospital] with sepsis, grade 4 sacral PI and osteomyelitis.

Note: Norton Scale PI risk assessments on 22 [Month1], 11 **[Month4]** and 10 **[Month6]** reflecting inaccurate assessment of resident's needs. Physical condition was assessed as 4 and should have been 3 due to compromised skin integrity. Mobility assessed as 3 (slightly limited) and should have been a 2 (requires extensive assistance as resident was a paraplegic). Incontinence assessed as 4 (total control of bladder and bowels) and

should have been a 1 (double-incontinence). If accurate assessment of Norton Scale was completed — this might have increased the risk of PI and triggered increased input from RNs.

Note: Until 27 **[Month7]** — the sacral PIs were not checked daily. Wound management plan of normal saline and foam dressing was basic and could have included more effective selection of dressings to allow autolytic debridement. It is also noted that documented evidence highlighted that [Mr A] at times did not conform with the treatments provided.

From the evidence reviewed to respond to these questions it appears the wound management oversight throughout the respite and permanent admission period was not in line with accepted nursing practice; and nursing staff have not adequately ensured interventions were appropriate and timely to treat and prevent decline and would be viewed similarly by my peers. Lack of accurate assessment of PI risk, lack of referral to GP or wound CNS and inadequate wound management plan is a moderate to severe deviation from accepted practice.

Departure from accepted practice: Moderate/ severe

Addendum 25th February 2025: The documented evidence is clear about the pressure injury/wound management, and I wouldn't be changing my advice about the deviation from accepted practice as stated above.

Whether communication between the facility and the GP was in line with accepted practice; and if there was a delay did this unnecessarily contribute to further decline of [Mr A's] wound?

As evidenced by the timeline provided above, the GP was unaware of the PIs from the time of admission in **[Month3]** until **[Month8]**. The discharge summaries from [the public] hospital following admissions in **[Month5]** and **[Month6]** received by GP did not contain information about sacral pressure injuries.

The management of pressure injuries requires that high-risk people (such as [Mr A]) are identified, and PI management plans are developed in collaboration with MDT [1]. The delay in referrals to GP and Wound CNS have likely contributed to further decline in [Mr A's] sacral pressure injuries.

From the evidence reviewed to respond to these questions the communication between the facility and the GP was not in line with accepted nursing practice and this may have contributed to a further decline in [Mr A's] sacral PIs and would be viewed similarly by my peers. **Departure from accepted practice: Moderate/severe.**

[1] Helping prevent pressure injuries (acc.co.nz)

Whether communication between the facility and the family is evidenced as acceptable?

28 [Month2] — Evidence of family notification of sacral PI during respite admission evidence of consultation on transfer to permanency and face to face meeting shortly after this to address initial concerns and change of room.

7 [Month3]— Further phone calls evidenced to family immediately following fall event and to advise of room move.

No further communication on the 'Whānau Record' until **[Month6]** about hospital admission, however during end **[Month4]** and **[Month5]** [Mr A] had several hospital admissions.

[Month7] — Consistent communication again evidenced following return to facility following acute admission to [the public hospital].

From the evidence reviewed to respond to this question the communication between the facility and the family from **[Month2]** until **[Month7]** was not in line with accepted practice and would be viewed similarly by my peers. **Departure from accepted practice: Moderate.**

Whether the facility have escalated a change in level of care in a timely manner as [Mr A's] needs increased?

As mentioned earlier, there is a concern about the appropriateness of InterRAI assessment as rest home level of care in **[Month3]**.

"The concern is that a resident who is a paraplegic, immobile, with double-incontinence and requiring high level of assistance with ADLs from staff is assessed to be suitable for rest home level of care. The more appropriate care level would seem to be of private hospital level of care. The higher level of care would have ensured monthly GP reviews for a resident with complex medical conditions and nursing needs. The InterRAI assessment process may not have been completed appropriately."

As per certification audit's report from July '22 — there was a partial attainment in the Pathway to Well-being standard, due to significant number of InterRAI assessments not completed. As well as care plans not reviewed within an acceptable timeframe.

From the evidence reviewed to respond to this question the assessment of [Mr A's] level of care from the time of admission to decline (between **[Month3]**–**[Month6]**) was not completed in a timely manner and would be viewed similarly by my peers. **Departure from accepted practice: Moderate.**

Addendum: 26 Nov 2024 — It was unclear from the documented evidence about who completed the first InteRAI assessment prior to [Month3] — most likely to have been Needs Assessor in the public hospital. The care home had the ability to question the

level of care on admission. I have amended the departure from accepted practice from Moderate to mild.

From the evidence reviewed to respond to this question the assessment of [Mr A's] level of care from the time of admission to decline (between **[Month3]**–**[Month6]**) was not completed in a timely manner and would be viewed similarly by my peers. **Departure from accepted practice: Mild**

In addition, I recommend that the care home implements a review of care planning process to ensure that residents' individual needs are clearly documented in a timely manner and in accordance with any changes. Education in wound management and assessment of pressure injuries including Norton Scale of PI risk, and timely referrals to GP, Wound CNS, and MDT, is recommended for RNs.

Several best practice guidelines are available in regard to management of pressure injuries such as "The Guiding Principles for Pressure Injury Prevention and Management in New Zealand" (2017)[2] and "Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury" (2012)[3].

Isabella Wright, NP, BHSC (Nursing), PGDipHSc (Advanced Nursing), MPH, Doctoral Candidate

Nurse Advisor (Aged Care)
Health and Disability Commissioner'

[2] Helping prevent pressure injuries (acc.co.nz)
[3] 2012_awma_pan_pacific_abridged_guideline.pdf

Appendix B: Mr A's wound charts and photos taken of pressure injury

Date	Type of wound	Width of wound	Length of wound	Depth of wound	Exudate	Pain scale	Photo of wound
1 **Month4**	Pressure injury (PI) stage 3	0.2cm	2cm	0.2cm	Moderate (type not stated)	No pain	
1 **Month5**							Photo taken
7 **Month5** 2019	PI stage 3	0 cm	2cm	Not noted	No exudate	No pain	Photo taken
25 **Month5**	PI stage 3	2cm	2cm	Not noted	No exudate	No pain	
13 **Month6**	PI stage 3	1.5cm	2.5cm	0.15cm	Moderate (type not stated)	No pain	
15 **Month6**	PI stage 3	1.5cm	2.5cm	0.15cm	Moderate (type not stated)	No pain	
27 **Month6**	PI stage 3	1.5cm	2cm	2cm	Heavy (type not stated)	No pain	Photo taken
1 **Month7**	PI stage 3	1.5cm	2cm	2cm	Heavy (type not stated)	No pain	
3 **Month7**	PI stage 3	1.5cm	2cm	2cm	Heavy (type not stated)	No pain	
7 **Month7**	PI stage 3	1.5cm	2cm	2cm	Moderate (type not stated)	Yes 5/10	
11 **Month7**	PI stage 3	1.5cm	2cm	2cm	Moderate (type not stated)	Yes 6/10	

15 **Month7**	PI stage 3	1.5cm	2cm	2cm	Heavy (type not stated)	Yes 6/10	
20 **Month7**	PI stage 3 'plus'	1.5cm	2cm	2cm	Non/minimal (type not stated)	No pain	
22 **Month7**	PI stage 3 plus	1.5cm	2cm	2cm	Moderate (type not stated)	No pain	
23 **Month7**	PI stage 3 plus	1.5cm	2cm	2cm	Moderate (type not stated)	No pain	
25 **Month7**	PI stage 3 plus	1.5cm	2cm	2cm	Non/minimal (type not stated)	Yes 6/10	
26 **Month7**							Photo taken
28 **Month7**	PI stage 3 plus	1.5cm	2cm	2cm	Non/minimal (type not stated)	Yes 2/10	
30 **Month7**	PI stage 3 plus	1.5cm	2cm	2cm	Non/minimal (type not stated)	Yes 4/10	
1 **Month8**	PI stage 3 plus	1.5cm	3cm	2cm	Moderate (type not stated)	Yes 5/10	Photo taken
2 **Month8**	PI stage 3 plus	1.5cm	3cm	2cm	Moderate (type not stated)	Yes 5/10	Photo taken
3 **Month8**	PI stage 3 plus	2cm	3cm	2.5cm	Heavy (type not stated)	Yes 5/10	
4 **Month8**	PI stage 3 plus	2.5cm	3cm	3cm	Heavy (type not stated)	Yes 5/10	

5 **Month8**	PI stage 3 plus	2.5cm	3cm	3cm	Heavy (type not stated)	Yes 5/10	
6 **Month8**	PI stage 3 plus	2.5cm	3cm	3cm	Heavy (type not stated)	Yes 6/10	
7 **Month8**	PI stage 3 plus	2.5cm	3cm	3cm	Heavy (type not stated)	Yes 8/10	

Appendix C: Mr A's pressure injury wound entries and communication between Dunblane and Mr A's GP and family.

Time and date	Pressure injury mentioned	Family communication	GP communication	Documented where?
3 Month2 at 10am		Regarding Mr A's extension of stay at Dunblane.		On Family/ Whānau communication record sheet.
4 Month2 at 11.37am	Carer noticed two broken areas on both cheeks and sacrum, RN informed.			In progress notes.
4 Month2 at 2.20pm	The nurse acknowledged the carer noted the broken areas on Mr A's bottom and sacrum, but states she was unable to check/view herself.			In progress notes.
7 Month2 at 7.30pm		Family visited regarding NASC assessment.		In progress notes.
9 Month2 at 11.00am		Message sent to Mr A's granddaughter regarding respite care.		In progress notes.
11 Month2 [time illegible]		Family visiting Mr A.		In progress notes.
12 Month2	'[S]ore on bottom healing.'			In progress notes.

Names (except Heritage Lifecare Limited (trading as Dunblane Lifecare) and the advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

at 1.20pm				
13 Month2 at 2.15pm		Family visited Mr A.		In progress notes.
22 Month2 at 4.00pm	'… [Mr A] stated he had a wounded area by his bottom that he wanted checked … visible redness [with] some broken skin to sacrum area.' Wound care plan and incident form done.			In progress notes.
25 Month2 at 2.30pm		Family visited Mr A.		In progress notes.
28 Month2 at 2.00pm	Dressing applied to sacrum to 'prevent further breakdown of tissue. Incident form filled out.'			In progress notes.
28 Month2 at 3.15pm		Phone call to granddaughter regarding pressure injury on Mr A's sacrum. She asked if rehab could be organised to help Mr A stay off his sacrum.		On Family/Whānau communication record sheet.
3 Month3	'Sacrum wound cleaned and new dressing applied			In progress notes.

at 12.00pm	[no] signs of infection. Photo taken of wound for documentation.'			
8 Month3 at 1.35pm	Wound nurse assessed sacrum and redressed it			In progress notes.
10 Month3 at 1.50pm	'Dressing intact'			In progress notes.
15 Month3 at 9.26am		Phone call to granddaughter regarding Mr A's fall in the early morning.		On Family/Whānau communication record sheet.
15 Month3 at 12.20pm		Dunblane to family — Voice message left regarding Mr A being assessed for rest home level care.		In progress notes.
15 Month3 at 1.10pm		Family visited.		In progress notes.
18 Month3 at 9.40pm	'Sacrum broken, RN informed'			In progress notes.
18 Month3 at 10.15pm	Notes that Mr A's sacrum cleaned.	Granddaughter visited.		In progress notes.
23 Month3		Dunblane to Mr A's wife and son		On Family/ Whānau

at 12.15pm		regarding room change for Mr A and concerns regarding cares.		communication record sheet.
23 Month3 at 1.15pm		Family visited and helped Mr A change rooms, and met with clinical nurse manager.		In progress notes.
24 Month3 at 9.40pm	'New dressing applied to wound on sacrum'			In progress notes.
26 Month3 at 11.30am	Noted the '[b]reakdown of skin' on Mr A's sacrum, with a possible stage two or three pressure injury. Photo of wound taken and clinical nurse manager notified.			In progress notes.
1 Month4 at 2.00pm	Mr A's wound dressing changed and wound management plan updated.			In progress notes.
3 Month4 at 9.30pm	'Dressing to sacrum renewed [and] documented in wound chart.'			In progress notes.
7 Month4 [no time noted]		Dunblane to granddaughter regarding Mr A's fall.		On Family/ Whānau communication record sheet.

8 Month4 at 9.20pm		Mr A's son visited.		In progress notes.
9 Month4 at 12.30pm	'I checked wound care plan — did a dressing on his sacrum …'			In progress notes.
11 Month4 at 9.30am		Dunblane to granddaughter — voice message left regarding Mr A moving room.		On Family/Whānau communication record sheet.
13 Month4 at 12.10pm	Dressing on Mr A's sacrum changed.			In progress notes.
14 Month4 at 6.50pm	'[W]ound was very smelly RN informed …'			In progress notes.
16 Month4 [time illegible]		Dunblane to Mr A's wife — Voice message left regarding Mr A being admitted to the hospital related to swelling of his legs.		On Family/Whānau communication record sheet.
16 Month4 at 3.10pm		Dunblane to granddaughter regarding Mr A being admitted to hospital for treatment of his swollen legs.		On Family/Whānau communication record sheet.

17 Month4 at 10.20am	'RN did dressing on [Mr A's] bottom.'			In progress notes.
				In progress notes.
18 Month4 at 9.20am	'… sacral dressing done today.'			In progress notes.
19 Month4 at 9.45am	RN expressed her concerns to the manager and clinical nurse manager, regarding Mr A needing two assistants to transfer in shower, and apply sacral dressing, suggesting his level of care be reassessed.			In progress notes.
20 Month4 at 2.14pm	Dressing changed on sacrum and photo taken of the wound.			In progress notes.
23 Month4 at 9.30am	Wound dressing on sacrum changed.			In progress notes.
25 Month4 at 9.14pm	'… noticed [Mr A] had no dressing on wound RN informed dressing applied …'			In progress notes.
27 Month4	'Alerted by [caregiver] that dressing on [Mr			In progress notes.

at 1.00pm	A's] sacrum [needed] to be changed soiled and smelly.' Dressing changed by RN.			
29 Month4 at 3.15pm	'Done dressing on sacrum. It's slowly improving … [s]till smelly.'			In progress notes.
1 Month5 [time illegible]	'Sacral dressing renewed appears to be improving.'			In progress notes.
3 Month5 at 12.45pm	Dressing changed on Mr A's sacrum as per wound care plan.			In progress notes.
3 Month5 at 9.30pm		Family visited Mr A.		In progress notes.
5 Month5 at 12.53pm	'Dressing on [Mr A's] bottom was re-done by RN.'			In progress notes.
6 Month5 at 9.30am	Dressing on Mr A's sacrum redressed as per short term care plan.			In progress notes.
8 Month5 at 11.00am	'Dressing off in shower needs redressing.'			In progress notes.
13 Month5 at 9.30am		Family visited Dunblane to pick up clothes for Mr		In progress notes.

		A while he was in hospital.		
18 Month5 at 10.40am	'… assisted the nurse to do [Mr A's] dressing on the pressure injury.'			In progress notes.
20 Month5 at 11.30am	Wound dressing changed on Mr A's sacrum			In progress notes.
23 Month5 at 9.30am	'Sacral dressing changed today.'			In progress notes.
23 Month5 at 5.30pm		GP faxed to review Mr A's 'overall condition' since discharge from the hospital.		In progress notes.
29 Month5 at 1.40pm	'Sacral dressing done as per wound care chart.'			In progress notes.
2 Month6 at 9.00pm	'RN dressed [Mr A's] sacral wound.'			In progress notes.
4 Month6 at 11.00am	'… sacral wound dressed as per wound care chart.'			In progress notes.
10 Month6 at 11.00pm			GP reviewed Mr A regarding oedematous feet.	In progress notes.

11 Month6 at 10.00am	'Sacral dressing done as per wound care chart.'			In progress notes.
13 Month6 at 11.20am	RN reviewed pressure injury on Mr A's sacrum and redressed it. Noted that the wound management plan was updated and that the clinical specialist nurse — wound care may need to be referred to for guidance.			In progress notes.
15 Month6 at 9.15am			GP contacted regarding Mr A's urine specimen.	In progress notes.
15 Month6 at 11.10am	'Wound dressing done on sacrum. Some improvement on wound bed … wound assessment done.'			In progress notes.
16 Month6 at 3.15pm		Family informed of Mr A's swollen legs and possible transfer to hospital.		In progress notes.
27 Month6 at 11.45am	'Wound dressing done [,] wound assessment and management plan updated … [pressure injury]			In progress notes.

	grade 3 — photo taken.'			
1 Month7 [time not recorded]	'[W]ound looks healthy and healing [d]ressing done.'			In progress notes.
2 Month7 at 7.00pm	'… dressing [pressure injury] on sacrum very saturated … changed new dressing applied.'			In progress notes.
7 Month7 at 12.30pm	[Mostly illegible entry but mentions a 'dressing' and 'pressure sore wound … healing']			In progress notes.
9 Month7 at 11.15am		Family visited Mr A.		In progress notes.
11 Month7 [time not recorded]	Mr A's sacral wound reviewed by specialist wound nurse.			In progress notes.
12 Month7 at 7.15pm	'RN did his dressing tonight.'			In progress notes.
13 Month7 at 10.40pm	'… dressed sacral wound'			In progress notes.
15 Month7 at 11.00am	'Had to get RN to do his dressing on his bottom. Pressure area is			In progress notes.

	getting bigger and infected.'			
16 Month7 at 2.50pm	'Wound dressing done on [Mr A's] sacrum. No signs of infection.'			In progress notes.
17 Month7 at 10.50pm		Granddaughter informed about incident in bathroom/toilet.		In progress notes.
17 Month7 at 7.52pm		Dunblane to granddaughter regarding Mr A hitting his head on the wall of the bathroom.		On Family/ Whānau communication record sheet.
20 Month7 [no time noted]		Dunblane to granddaughter — Voice message left regarding an outpatient appointment for Mr A on 27 Month7.		On Family/ Whānau communication record sheet.
20 Month7 at 11.00am	'Dressing done. Wound looking good [and] healthy. No signs of infection.'			In progress notes.
20 Month7 at 7.56pm	'Pressure area on [Mr A's] bottom appears smelly.'			In progress notes.
21 Month7 at 10.15am		Granddaughter informed of Mr A falling.		In progress notes.

21 Month7 [no time noted]		Granddaughter to Dunblane staff — Family very concerned about Mr A having fallen twice this week.		On Family/ Whānau communication record sheet.
22 Month7 at 10.35am		Dunblane staff to granddaughter — Voice message left regarding Mr A falling.		On Family/ Whānau communication record sheet.
23 Month7 at 10.45am	'Wound dressing done. Looks free from injection, healing slowly.'			In progress notes.
24 Month7 [no time noted]		Dunblane to granddaughter — Voice message regarding a near miss incident and if anyone could escort him to his outpatient appointment.		On Family/ Whānau communication record sheet.
25 Month7 at 1.40pm	Dressing on sacrum changed by RN.			In progress notes.
26 Month7 at 1.55pm	'[D]ressing re-done by RN …'			In progress notes.
28 Month7 at 10.15am	'Wound dressing changed, improving slowly. Nil sign of infection.'			In progress notes.

29 Month7 at 9.30pm	'RN did the dressing.'			In progress notes.
30 Month7 at 10.50am	'Foam dressing applied.'			In progress notes.
1 Month8 at 12.30pm	Dressing changed on Mr A's sacrum.			In progress notes.
2 Month8 at 10.30pm	'Dressing done on pressure [area] on [Mr A's] buttocks.'			In progress notes.
3 Month8 at 11.00am	Clinical nurse specialist — wound care, review of Mr A's sacral pressure injury. 'Sacral [pressure injury] deeper with breakdown at top of buttocks.' She spoke to surgeon regarding surgical debridement of wound.			In progress notes.
3 Month8 [no time noted]		Dunblane to wife — Regarding Mr A going to the hospital on the 9th or 10th of Month8, for pressure injury treatment.		On Family/ Whānau communication record sheet.

3 Month8 [no time noted]		Mr A's wife informed of Mr A's appointment for debridement of his pressure injury wound.		In progress notes.
4 Month8 at 3.00pm	Mr A's 'wound dressing done … very oozy. Wound assessment and management plan updated.'			In progress notes.
5 Month8 at 1.15pm	'Wound dressing done … very smelly and exudate + + + Wound assessment and management [plan] updated … [wound specialist nurse] visited happy about the way dressing done.'			In progress notes.
6 Month8 at 1.30pm	Wound redressed by nurse notes that wound is 'smelly' with 'exudate + + +.'			In progress notes.
7 Month8] at 10.30am	Dressing on sacrum changed '[w]ound is excoriated and breaking. Foul smell exudate + + +.'			In progress notes.
7 Month8 in the late afternoon, Mr A was transferred to hospital.				

8 Month8 [no time noted]		Family went to Dunblane to collect Mr A's belongings.		On Family/ Whānau communication record sheet.
10 Month8 [no time noted]		Family cancelled family meeting.		On Family/ Whānau communication record sheet.
15 Month8 [no time noted]		Mr A's wife arranging a family meeting with Dunblane for 18 Month8.		On Family/ Whānau communication record sheet.
Month8 — sadly, Mr A passed away.				