(1) ORDER PROHIBITING PUBLICATION OF NAME, ADDRESS OR IDENTIFYING PARTICULARS OF AGGRIEVED PERSON AND OF HIS WIFE

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2015] NZHRRT 50**

Reference No. HRRT 070/2015

UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**RADIUS RESIDENTIAL CARE LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines QC, Chairperson
Dr SJ Hickey MNZM, Member
Mr RK Musuku, Member

REPRESENTATION:
Ms N Wills, Director of Proceedings
Mr N Beadle and Ms M Henaghan for defendant

DATE OF DECISION: 23 November 2015

DECISION OF TRIBUNAL[1]

---

[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 13 November 2015.

[1] [This decision is to be cited as: *Director of Proceedings v Radius Residential Care Ltd* [2015] NZHRRT 50]

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

> **[2.1]** A Consent Memorandum dated 13 October 2015.
>
> **[2.2]** An Agreed Summary of Facts, a copy of which is annexed and marked "A".

[3] The Consent Memorandum is in the following terms:

> **MAY IT PLEASE THE TRIBUNAL**
>
> 1. The plaintiff and defendant have agreed upon a summary of facts on the basis of which the parties seek a declaration in paragraph 3(a) below. A signed copy of the agreed facts is filed with this memorandum. The parties are agreed that it is not necessary for the Tribunal to consider any other evidence for the purpose of making the declaration sought. The parties request that the agreed summary of facts be published by the Tribunal as an addendum to the decision.
> 2. The aggrieved person in this matter is the deceased consumer (who died in July 2015) through the executrix of his estate.
> 3. The plaintiff requests that the Tribunal exercise its jurisdiction in respect of the following matters:
>   (a) A declaration pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of:
>   (i) Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.
>   (b) The plaintiff seeks a final order prohibiting publication of the name of the consumer in this matter and his wife, the executrix of his estate. The defendant consents to such final orders being granted.
> 4. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts and the non-publication order sought in paragraph 3(b).
> 5. In the statement of claim the plaintiff also sought the following relief:
>   (a) damages pursuant to s 57(1); and
>   (b) costs.
> 6. These other aspects of the relief claimed by the plaintiff have been resolved between the parties by negotiated agreement. There is no issue as to costs.
> 7. The defendant does not seek any order prohibiting publication of the defendant's name.

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that an action of the defendant was in breach of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 3(a) of the Consent Memorandum.

DECISION

[5] By consent the decision of the Tribunal is that:

> **[5.1]** A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.
>
> **[5.2]** A final order is made prohibiting publication of the name, address and any other details which might lead to the identification of the aggrieved person and of his wife. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

....	....	....
Mr RPG Haines QC **Chairperson**	**Dr SJ Hickey MNZM** **Member**	**Mr RK Musuku** **Member**

"A"

This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 23 November 2015.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT

UNDER	Section 50 of the Health and Disability Commissioner Act 1994
BETWEEN	**THE DIRECTOR OF PROCEEDINGS** designated under the Health and Disability Commissioner Act 1994 **Plaintiff**
AND	**RADIUS RESIDENTIAL CARE LIMITED** a limited liability company having its registered office at Ground Floor, 12 Viaduct Harbour Avenue, Auckland, New Zealand **Defendant**

AGREED SUMMARY OF FACTS

Level 11, 86 Victoria Street, Wellington 6011

PO Box 11934, Wellington 6142

Phone: 04 494 7900 Fax: 04 494 7901
Nicola Wills - Director of Proceedings

SUMMARY OF FACTS

INTRODUCTION: RADIUS RESIDENTIAL CARE LIMITED

1. The defendant is, and was at all material times:

   a. a limited liability company, with its registered office at Ground Floor, 12 Viaduct Harbour Avenue, Auckland, New Zealand;

   b. a specialist health and aged care provider for elderly and disabled persons;

   c. an operator of 20 residential aged care facilities throughout New Zealand for more than 1400 residents covering residential care, hospital care, dementia care, respite care and palliative care;

   d. a healthcare provider within the meaning of section 3 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The defendant owns and operates, and at all material times was owning and operating, the facility known as Radius St Winifred's Hospital at 10 St Winifred's Place, Bryndwr in Christchurch ("St Winifred's).

St Winifred's

3. St Winifred's is, and was at all material times, an aged care facility accommodating hospital care, palliative care, respite care and dementia care patients, and specialising in providing hospital and dementia care.

4. St Winifred's employs, and employed at all material times, a Facility Manager and a Clinical Nurse Manager.

5. In addition, St Winifred's employs, and at all material times employed, a number of registered nurses, enrolled nurses and healthcare assistants.

THE AGGRIEVED PERSON: THE ESTATE OF MR A

6. The aggrieved person is the deceased consumer, ("Mr A"), through the executrix of his estate ("Mrs A"), then living at Christchurch with his wife Mrs A and their adult son (Mr A's son).

7. Mr A was a 72 year old man with multiple co-morbidities, including chronic renal impairment, pulmonary vascular disease, type II diabetes, diabetic retinopathy, high blood pressure, ischaemic heart disease, and dyslipidaemia.

8. Before his stay at St Winifred's in 2012, Mr A had also undergone a right leg angioplasty for critical limb ischaemia. His left leg had been amputated below the knee and he had suffered with chronic infective ulceration wounds on his right big toe and heel since 2008 (the "right foot wounds").

9. From 2008 until the time of his admission to St Winifred's, the right foot wounds had been managed and treated in the community by a district nursing service ("District Nursing Service").

10. On 21 May 2012, the District Nursing Service re-dressed the right foot wounds, which remained stable with "*thick slough*" noted to be present.

11. On 24 May 2014, the day Mr A was admitted to St Winifred's, Mr A visited his podiatrist. His podiatrist noted that the right foot wounds had a "*thin sloughy layer*" and he dressed a new skin tear on Mr A's right leg.

BACKGROUND: MR A'S STAY AT ST WINIFRED'S

Admission

12. From 24 May 2012 to 12 June 2012, when Mr A was 70 years old, he was admitted to respite care at St Winifred's while Mrs A was overseas in the United Kingdom visiting family members. At the time of his admission to St Winifred's, Mr A was suffering from the conditions outlined in paragraphs 7 and 8 of this Agreed Summary of Facts. Mr A also had a skin tear on his right leg as outlined in paragraph 11 of this Agreed Summary of Facts (the "skin tear").

13. At the time of his admission to St Winifred's on 24 May 2012, Mrs A wrote a note to accompany Mr A on admission, noting that "*Mr A has torn the skin on the front of his right leg today. Rather a mess. The podiatrist has dressed it today but says it needs to be checked tomorrow and redressed. His heel and toe was dressed today. It needs dressing each Monday and Thursday.*"

14. In addition, at the time of Mr A's admission to St Winifred's, Mrs A provided the admitting nurse Registered Nurse E ("RN E") with an open box containing crêpe bandages and latex-free Omnifex dressing, case notes from the dressing done by the District Nursing Service on 21 May 2012, and case notes from his podiatrist from the morning of 24 May 2012.

The Care Plan

15. RN E completed a "Respite/Short Term Assessment, Care & Discharge Plan" (the "Care Plan") on 24 May 2014 which recorded that Mr A had declined mobility and used a manual wheelchair, was diabetic, cognitively impaired and required assistance with toileting, personal cleansing and dressing, controlling his body temperature, skin/pressure area care, and safety/mobility.

16. In the "special care requirements" section of the Care Plan, RN E noted the skin tear, for which the care plan was to "*check dressing daily, change when strike through.*" RN E did not record the latex-free bandages and dressings provided by Mrs A for use on her husband's dressings or her request that latex-free dressings be used on Mr A's wounds (as recommended by Mr A's podiatrist).

17. RN E did not document either of the right foot wounds in the "special care requirements" section of the Care Plan or complete a separate wound care plan (the "Wound Care Plan") containing a wound review form (the "Wound Review Form") for either of the right foot wounds.

18. RN E did not document Mr A's baseline observations (temperature, blood pressure, pulse, respiration) in the Care Plan.

19. RN E did not complete or record skin or pressure risk assessments, except to circle on an assessment form the words, "*wound*" and "*bruising*" and to mark on that assessment form under the heading "*Skin/Pressure Area Care*", a "*D*" for "*Dependent*".

20. The Care Plan contained no detailed management plan on how to avoid Mr A's pressure area risks or how to maintain his skin integrity.

21. The Care Plan contained no wound care assessment (discussed further below in this Agreed Summary of Facts), falls risk assessment and continence assessment (except to circle on an assessment form the word "*commode*" with an accompanying handwritten note, "*bottle at night*" and to make on that assessment form under the heading "*Elimination*", a "*D*" for "*Dependent*".

The Skin Tear Wound Plan

22. The assessment of Mr A upon his admission to St Winifred's was completed by the Enrolled Nurse J ("EN J") on the afternoon of 24 May 2012. EN J completed a "Wound Assessment & Care Plan" dated 24 May 2012 (the "Skin Tear Wound Plan") for Mr A.

23. The Skin Tear Wound Plan referred to the skin tear and made no reference to either of the right foot wounds. EN J did not make note of the non-latex bandages and dressings provided by Mrs A, or the reason Mrs A provided those bandages and dressings.

24. No separate Wound Care Plans were completed by EN J for either of the right foot wounds.

25. The Skin Tear Wound Plan contained a wound review form (the "Wound Review Form") to be used by nursing staff to record the status of wounds and dressing changes. The Wound Review Form has space to record the date of each wound assessment, the frequency of dressing changes and nine sections for the assessing person to complete, being wound size, wound bed, wound margins, exudation, odour, pain from wound, whether wound infection suspected, evaluation overview and wound review. The Wound Review Form

also contains a space for the assessing person to sign after wound review has been carried out.

26. The Skin Tear Wound Plan noted that the dressing change was to occur every second day, with the next change due on 26 May 2012.

Progress Notes

27. In addition to the Skin Tear Wound Plan, nursing staff at St Winifred's used progress notes to record Mr A's general nursing notes (the "progress notes").

28. The details of Mr A's wound care were recorded on some occasions on the Skin Tear Wound Care Plan and on other occasions in the progress notes.

Care during his stay

29. Mr A was admitted to the Sumner Wing of St Winifred's and, during his stay, was attended to by a total of six registered nurses, four enrolled nurses and a number of health care assistants.

Care of the right foot wounds

30. On 25 May 2012, EN J *"re-dressed skin tear on R.L. upper legs as per care plan"* and recorded this in the progress notes. EN J did not record this re-dressing of the skin tear on the Skin Tear Wound Plan and did not complete the Wound Review Form.

31. On 28 May 2012, Registered Nurse G ("RN G") cleaned the skin tear with Betadine and covered it with Hydrofilm®(a self-adhesive dressing with an absorbent wound pad to protect exuding wounds) and recorded this on the Skin Tear Wound Plan. RN G also noted this

dressing change in the progress notes, in which she also wrote, "*noticed pressure sore [right] heel*."

32. RN G cleaned the right heel wound with Betadine and covered it with gauze and Tegaderm and wrote this on the Skin Tear Wound Plan. RN G amended the Skin Tear Wound Plan to also refer to the right heel pressure sore but she did not complete a new Wound Care Plan for the right heel pressure sore or for the right toe sore. RN G did not record the type of dressings to be used, the frequency of dressing changes or any other details about the care and management of the right heel wound.

33. On 2 June 2012, Enrolled Nurse K ("EN K") cleaned Mr A's wound (unidentified), re-dressed the unidentified wound with Hydrofilm® and re-dressed Mr A's right toe. EN K recorded this cleaning and redressing on the Skin Tear Wound Plan. EN K noted on the Wound Review form in the Skin Tear Wound Plan that this was her "first sighting". EN K did not complete a new Wound Care Plan for the right toe.

34. On 4 June 2012, a healthcare assistant wrote in the progress notes, *inter alia, "Also about dressings, no other notable concerns."* A note in the margin of the progress notes states "*undocumented dressing changed*". The Wound Review Form in the Skin Tear Wound Plan was not completed.

35. On 6 June 2012, at 8.45 pm, Registered Nurse F ("RN F") recorded in the progress notes, "*pain…right toe wound measured approx. 1.5cm x 1cm x 2mm, wound bed is black and necrotic. Wound washed with saline and debrided necrotic tissue. PolyMem on wound and covered with gauze and secured by Omnifix. Wound chart written.*" RN F completed a new

Wound Care Plan for the right toe wound (the "Toe Wound Care Plan") with a separate Wound Review Form which recorded that the right toe wound was a pressure sore, the primary dressing was to be PolyMem and the secondary dressing gauze, and that the dressing was to be changed every two days, with the next dressing due on 8 June 2012.

36. Despite the necrosis noted, RN F did not take a wound swab of the right toe wound to check for infection and did not inform Mr A's general practitioner Dr C of the necrosis observed in Mr A's right toe. RN F did not communicate the deteriorating wound status to Mr A's family.

37. RN F did not review or change the dressings on Mr A's right heel or the skin tear on 6 June 2012.

38. The Wound Review Form in the Skin Tear Wound Plan was not completed on 6 June 2012. Nothing was noted about Mr A's heel wound or skin tear in his progress notes on 6 June 2012.

39. On 9 June 2012, Registered Nurse H ("RN H") *"cleaned [an unidentified wound] with betadine and covered with polymin [sic][1]. Toe – polymin [sic]. Upper leg hydrofilm plus."* RN H recorded this cleaning and dressing on the Skin Tear Wound Plan. RN H noted on the Wound Review Form in the Skin Tear Wound Plan that the wound bed was "*granulating (red)*", that the wound margins were "*inflamed*" and that the wound's exudation was "*moderate*". RN H did not specify which wound her notes referenced.

---

[1] The correct term is "Polymem®" which is a type of bandage.

40. RN H did not make any notes in the Toe Wound Care Plan. Despite the signs of infection, RN H did not take a wound swab of the right foot wounds and did not inform Dr C of the changes in the right foot wound status. RN H did not communicate the deteriorating wound status to Mr A's family.

41. On 11 June 2012, Enrolled Nurse L ("EN L") cleaned and dressed Mr A's wounds (unidentified), noting on the Wound Review Form in the Skin Tear Wound Plan that the wound margins (unidentified wound) were "*inflamed*". EN L recorded that the wound (unidentified) was "*granulating (red).* EN L cleaned the wound (unidentified) with Betadine and covered it with polymem and Hydrofilm® and recorded this on the Wound Review Form in the Skin Tear Wound Plan. EN L noted in the Skin Tear Wound Plan that the wound was "*first sighted*" by her on that date.

42. Also on 11 June 2012, EN L recorded on the Wound Review Form in the Toe Wound Care Plan that the toe wound bed was "*granulating (red), sloughy (yellow) and necrotic (black).*" EN L recorded that the toe wound margins were "*intact/healthy*" and that exudation was "*low*". She recorded "*No*" for the boxes referring to "*odour*", "*pain from wound*", "*requires analgesia/dressing change*" and "*wound infection suspected*". EN L cleaned the wound with water and Betadine and covered it with a polymem stocking, recording this dressing and change on the Wound Review Form in the Toe Wound Care Plan and noting that the wound was "*1st seen*" by her that day.

43. Despite the signs of infection and/or necrosis, EN L did not take a wound swab of either of the right foot wounds and did not inform Dr

C of any concerns with either of the right foot wounds. EN L did not communicate the deteriorating wound status to Mr A's family.

44. Also on 11 June 2012, at 11.40 am, a healthcare assistant wrote in the progress notes that "*found the dressing came off, informed RN*". There is no entry in the progress notes, the Skin Tear Wound Plan, or the Toe Wound Care Plan recording that the dressings on either of the right foot wounds had been replaced.

45. No dressing changes for the skin tear or the right heel wounds were carried out on 26 May 2012, 30 May 2012, 1 June 2012, and 8 June 2012, and/or every second day as required by the Skin Tear Wound Plan.

46. No dressing changes for the right big toe wound were carried out on 8 June and 10 June 2012 as required by the Toe Wound Care Plan.

47. No wound swabs were taken to check for infection at any time once signs of infection (inflamed wound margins) and/or necrosis were observed during Mr A's stay at St Winifred's, nor was Dr C advised of any change in the condition of his wounds. Mr A's family was never informed of the deteriorating status of any of his wounds.

48. At all times during Mr A's stay at St Winifred's, latex bandages were used to dress the right foot wound and the skin tear. The crêpe bandages supplied to St Winifred's by Mrs A on Mr A's admissions were never used and were given back to Mrs A upon Mr A's discharge from St Winifred's.

Events after Mr A's stay at St Winifred's

49. Mr A was discharged from St Winifred's on 12 June 2012. On the day of his discharge, a "Discharge Plan" was completed, which recorded

that Mr A was to return home with Mrs A. The Discharge Plan did not document any change in either of the right foot wounds or the skin tear.

50. On 13 June 2012, Mrs A noticed significant deterioration to the three wounds and, in particular, to the wound on Mr A's right big toe. Mrs A took Mr A to see Dr C that day. Dr C prescribed Mr A oral antibiotics.

51. On 14 June 2012, the District nursing service visited Mr A at his home and recorded that, *"Today strikethrough +, toe has deteriorated +++ since I last viewed. Is black, pulpy around where toe nail was. Cellulitis coming up foot both top and bottom – marked with me. Bottom of foot swollen. Also small wounds on both 2nd and 3rd toes…Heel wound has also deteriorated, periwound macerated and ulcer is deeper, minimal slough."*

52. Later that day, on 14 June 2012, Mr A was admitted to Christchurch Hospital with gangrene of his right big toe.

53. Mr A's right leg was amputated above the knee on 13 July 2012.

54. In July 2012, Mr A's wife, Mrs A, complained to the Health and Disability Commissioner about services provided to Mr A at St Winifred's between 24 May 2012 and 12 June 2012.

55. Since the complaint Radius St Winifreds has implemented the following changes:

    a. The introduction of a wound care nurse who sights and assesses every wound, and draws up the Wound Care Plan. Radius St Winifred's recognised that there were too many occasions where the nurse attending to Mr A's wounds had not seen them before

b. Radius St Winifred's now uses respite patients' own dressings and not ward stock.

c. Each wound, pressure sore, or skin tear has a separate wound care plan and well documented dressing changes.

56. In addition, Radius St Winifred's obtained two wound care audits from June 2013 which show improvement with wound care documentation and interventions.

57. On 26 September 2014 the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

58. Mr A passed away in July 2015. Mrs A is the sole executrix of his estate.

RELEVANT STANDARDS

The New Zealand Health and Disability Sector Standards

59. All hospitals, rest homes and some providers of residential disability care in New Zealand are required to meet the New Zealand Health and Disability Services Standards 2008 (the "2008 Standards") which are intended to assist providers to meet their obligations under the Code of Health and Disability Services Consumers' Rights 1996 (the "Code").

60. The 2008 Standards are made up of four sets of standards:

a. NZS 8134.0:2008 Health and Disability Services (General) Standard.

b. NZS 8134.1:2008 Health and Disability Services (Core) Standards (the "Core Standards").

c. NZS 8134.2: 2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.

d. NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards.

61. The Foreword to the Core Standards states that:

> NZS 8134.1 ensures:
>
> (a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;
>
> (b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;
>
> (c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and
>
> (d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

62. Standard 1.8 of the Core Standards requires that:

Standard 1.8	**Consumers receive services of an appropriate standard**
Criterion	The criterion required to achieve this outcome shall include the organisation ensuring:
	1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice

63. Standard 2.8 of the Core Standards requires that:

Standard 2.8 Consumers receive timely, appropriate and safe service from suitably qualified/skilled and/or experienced service providers

Criterion The criterion required to achieve this outcome shall include the organisation ensuring

2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

64. Standard 2.9 of the Core Standards requires that:

Standard 2.9 Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

2.9.2 The detail of information required to manage consumer records is identified relevant to the service type and setting.

….

2.9.6 Management of health information meets the requirements of appropriate legislation and relevant professional and sector standards where these exist.

…..

2.9.8 Service providers use up-to-date and relevant consumer records.

2.9.9 All records are legible and the name and designation of the service provider is identifiable.

2.9.10 All records pertaining to individual consumer service delivery are integrated.

Radius Policies

65. In addition, the defendant has in force a number of policies, relevant to the care and treatment of Mr A and of Mr A's right foot wounds (the "Radius Policies") which applied at all material times.

66. The "Assessment, Care Planning & Review Clinical Manual – Policy and Procedure" (the "Clinical Manual") includes the following:

5.1 Assessment

On admission of a client to a Radius Residential Care facility, the Registered Nurse responsible for admitting the client will complete the Initial Assessment/Care plan during the shift on which the client is admitted.

….

5.2 Care Planning

…

5.2.4 Care plans reflect evidence based good practice.

5.2.5 The care plan is to identify client needs/goals which are realistic, achievable and acceptable to the client with appropriate evidence/researched based interventions…

5.2.6 Short term care plans are to be developed for an acute needs [sic] which are likely to be resolved within four weeks such as a urinary tract infection, wound care plan, respiratory infection etc.

5.3 Review/Evaluation

…

5.3.3 The client's multidisciplinary progress notes are to reflect the daily care delivered to the client in accordance with the care plan, and form the documented criteria on which care plans are reviewed/evaluated.

5.3.4 Acute alteration in the client's condition requires review of the care plan immediately to ensure that on going [sic] care delivery is appropriate and acceptable to the client.

5.3.5 Short term care plans are to be reviewed daily with appropriate documentation of this in the multidisciplinary progress notes.

5.4 Facilitating Family & Whanau Involvement in Care Planning & Review

Family/whanau is to be consulted and included in care planning for clients at all times.

67. The "Clinical Records Policy & Procedure" (the "Clinical Records Policy") applies to all members of the multidisciplinary team treating a patient and includes the following:

1.0 OUTCOME

- Fully integrated multidisciplinary clinical records will be maintained for each client from the point of first contact with the organisation to the end of service.
- The clinical records will provide an accurate account of care delivered and permit communication among health professionals.
- Clinical records will demonstrate the continuum of service based on an ongoing process of assessment, planning care, setting goals and evaluation.

….

5.9 Progress and Review

5.9.1 Each member of the clinical team will document health information in a single, continuous record on the Multidisciplinary Progress Notes.

5.9.2 The Medical Officer prepares a Problem List of active and inactive problems. This is placed in the Medical section.

68. The "Skin Care Policy & Procedures" (the "Skin Care Policy") is applicable to all clients of Radius Residential Care in all care facilities and includes the following:

1.0 OUTCOME/POLICY

Radius Residential Care believe that in order for clients to maintain good physical health, optimal assessment and care of clients [sic] skin is important for good healthcare delivery. Therefore comprehensive assessment of clients [sic] skin, and risk assessment of potential for skin breakdown/pressure area development, are undertaken during the admission process, and on an ongoing basis. Following assessment of skin integrity/pressure area risk, appropriate nursing interventions acceptable to and planned in conjunction with clients will be implemented to promote healthy skin integrity and prevent breakdown/injury to clients [sic] skin.

….

5.0 PROCEDURE

5.1 Assessment

1. On admission to a Radius Residential Care facility an initial assessment/care plan will be completed for each client within eight hours of admission by a Registered Nurse. This initial care profile will identify any immediate risk that a client may have for the breakdown of pressures [sic] areas.

….

5.2 Care planning

1. Following comprehensive assessment of skin integrity and pressure area risk, clients who require intervention….to maintain skin integrity and prevent pressure area breakdown will have these needs identified in a care plan developed in conjunction with the client/whanau. On going [sic] review of effectiveness of intervention is to be documented and appropriate alterations to intervention documented and implemented.

69. The "Wound Care Policy & Procedures" (the "Wound Care Policy") includes the following:

1.0 OUTCOME/POLICY

Radius Residential Care believes that clients who have a wound, or their skin integrity is compromised, require nursing intervention that is safe, appropriate and acceptable to the client. Nursing interventions are to be evidence based and delivered in a professional and timely manner to meet the requirements of clients.

2.0 SCOPE

In a Radius Residential Care facility a Registered Nurse will make the initial assessment of a wound and develop a care plan that is appropriate for optimal wound healing and acceptable to the client. Both Registered and Enrolled Nurses will deliver wound care in accordance with the documented wound care plan. If an Enrolled Nurse is concerned about a wound due to delayed healing, pain, infection etc, then the wound needs to be reviewed by a Registered Nurse and care plan altered as necessary and/or appropriate intervention or referral made to Medical Officer.

….

5.0 PROCESS

Wound are [sic] involves all of the stages of the Nursing Process, i.e. assessment, care planning, intervention and evaluation.

All wounds will be thoroughly assessed and care plan formulated with interventions appropriate for the specific wound and requirements of the client, including documentation of ongoing evaluation and dressing changes. These processes will be completed on the Wound Assessment/Care Plan/Evaluation form.

All wound care interventions are to be conducted in a manner which protects the clients [sic] right to privacy and dignity. Clients, family/whanau [sic] are to be involved in wound assessment and care planning and interventions are to be acceptable to the client……

Wound care is to be delivered in accordance with this policy and in accordance with infection control polices and in an aseptic manner at all times.

5.1 WOUND ASSESSMENT

Clients who require wound care must have a wound assessment completed by a Registered Nurse.

EXPERT ADVICE RECEIVED

70. An independent nursing expert in aged care, Ms Carolyn Evans has provided expert advice in relation to the care provided to Mr A.

71. Ms Evans is a Registered Nurse who completed her Bachelor of Nursing degree at Waikato Institute of Technology in 2003. She spent time working at Waikato Hospital in the Oncology Department and Operating Theatre, before commencing as Nurse Manager of Windermere Rest Home in Cambridge in 2005 where her responsibilities included managing the care of 21 residents, recruitment, training and supervision of all nursing and allied staff,

liaising with families and health professionals and developing quality management systems, including auditing and assessments. Ms Evans now practices as an independent nursing consultant.

72. Ms Evans reviewed the complaint and supporting documents, the response to the complaint from St Winifred's, Mr A's clinical notes from the Canterbury DHB, and Mr A's clinical notes from St Winifred's.

73. Ms Evans considered whether the nursing care provided by St Winifred's was appropriate and whether the wound care provided to Mr A by St Winifred's was consistent with expected standards of care.

74. Ms Evans advised that, relevantly:

    a. The failure by St Winifred's to complete a sufficiently detailed Short Term Care Plan for Mr A providing baseline information, health status, abilities, supports and needs, and assessing the patient's health and support needs to maintain a level of functioning during respite care (including in Skin Integrity and Management Risk Assessment, Pressure Risk Assessment and Pressure Ulcer Staging, Nutrition and Diet Assessment, Wound Care Assessment, Pain Assessment, Falls Risk Assessment and Continence Assessment) was a moderate to severe departure from expected standards of care.

    b. The failure by St Winifred's to complete a Skin Integrity and Management Risk Assessment, and Pressure Risk Assessment, for Mr A, was a moderate departure from expected standards of care.

c. The failures by St Winifred's to take wound swabs when signs of infection (inflamed wound margins) and/or necrosis were present or advise Mr A's GP of a change in wound status were moderate to severe departures from expected standards of care.

d. The failure to communicate the deteriorating wound status of Mr A's wounds on his toe and heel to Mr A's family or GP once signs of infection (inflamed wound margins) and/or necrosis was a moderate to severe departure from expected standards of care.

e. The failure by St Winifred's to use appropriate care and skill in assessing, planning, implementing and evaluation Wound Care Assessment for Mr A was a moderate to severe departure from expected standards of care.

BREACH – RIGHT 4(1) OF THE CODE

75. The defendant accepts that its actions as particularised in the statement of claim, and described in this agreed summary of facts, amount to a breach of right 4(1) of the Code.

76. The defendant accepts the expert advice set out in paragraphs 70 to 74 above and accepts that the advice accords with its understanding of the care and skill required in the provision of services to consumers.

77. For the removal of doubt, the defendant accepts that, on the basis of the above facts, the statement of claim has established that the defendant has failed to provide with Mr A with services of reasonable care and skill as those services are set out in the Core Standards and in the Radius Policies.

____

Nicola Wills
Director of Proceedings

I, Brien Herbert Cree, Managing Director, on behalf of Radius Residential Care Limited, agree that the facts set out in this Summary of Facts are true and correct.

____

Brien Herbert Cree

28 September 2015
Date