(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON

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

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2022] NZHRRT 17**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 007/2022
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**THE ULTIMATE CARE GROUP LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms GJ Goodwin, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms BL Klippel, Member

REPRESENTATION:
Ms C McCulloch for the Director of Proceedings
Ms K McLuskie for defendant

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **8 April 2022**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v The Ultimate Care Group Ltd* [2022] NZHRRT 17. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 25 February 2022.

[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 Statement of Claim dated 24 February 2022.

[2.2] A Consent Memorandum dated 24 February 2022.

[2.3] An Agreed Summary of Facts, a copy of which is annexed and marked 'A'.

[3] In the Consent Memorandum dated 24 February 2022 the parties request that the Tribunal exercises its jurisdiction and issues:

> 2(a) A declaration pursuant to section 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 Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>
> 2(b) A final order pursuant to s 107(3)(b) of the Human Rights Act 1993 prohibiting publication of the name and identifying details of the aggrieved person in this matter (Mr A (deceased)).

[4] Having considered the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached 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 2(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person, for the following reasons.

[6] The Tribunal may order final name suppression under s 107(3) of the Human Rights Act 1993 if it is "satisfied it is desirable to do so". In this context, "desirable" is considered from the point of view of the proper administration of justice; a phrase that must be construed broadly to accommodate the particular circumstances of individual cases as well as broader public interests. Any name suppression order should do no more than is necessary to achieve the proper administration of justice. For an order there must be some material before the Tribunal to show specific adverse consequences that are sufficient to justify an exception to the fundamental rule of open justice; see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 and *Director of Proceedings v Brooks (Application for Final Non-Publication Orders)* [2019] NZHRRT 33.

[7] This claim arose following the death of Mr A, who was a consumer of the services provided by The Ultimate Care Group Limited ("Ultimate Care").

[8] Ultimate Care has acknowledged its failure to provide services to Mr A with reasonable care and skill. There is public interest in the details of Ultimate Care's failures being published, as set out in the detailed Agreed Summary of Facts. This, however, involves Mr A's very sensitive and private health information. There is little or no public interest in the publication of Mr A's name, nor in him being identified in connection with this case.

[9] Publication of Mr A's name and identifying details would cause his family distress, and their preference is that his name is suppressed. They, too, would be identified by publication of Mr A's name. In the circumstances the privacy interests of the aggrieved person and his family, outweigh any public interest in knowing his name.

[10] The presumption of open justice is satisfied by publication of the Tribunal's decision and the very detailed Agreed Summary of Facts, with Mr A's name and identifying details redacted.

[11] Accordingly, the Tribunal is satisfied the order sought by the parties in paragraph 2(b) of the Consent Memorandum should be made.

DECISION

[12] The decision of the Tribunal is that:

> **[12.1]** 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.
>
> **[12.2]** A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person, Mr A (deceased).
>
> **[12.3]** There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms GJ Goodwin	**Dr SJ Hickey MNZM**	**Ms BL Klippel**
Deputy Chairperson	**Member**	**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 8 April 2022

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT 007/22

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **THE ULTIMATE CARE GROUP LIMITED** a duly registered company having its registered office at Level 7, 117 Lambton Quay, Wellington

Defendant

REDACTED AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Courtney McCulloch – Counsel for Director of Proceedings

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by s 15 of the Health and Disability Commissioner Act 1994.

2. The "aggrieved person" is Mr A (deceased).

3. At all material times the defendant was a duly registered company which owned and operated Ultimate Care Karadean Court ("Karadean Court") in Oxford, Canterbury, where the aggrieved person was a resident.

4. At all material times, the defendant was a healthcare provider and/or disability services provider within the meaning of ss 2 and 3 of the Act, and was providing health services and/or disability services to the aggrieved person.

5. On 28 February 2017 the aggrieved person's daughter and two of the aggrieved person's sons complained to the Health and Disability Commissioner about services provided to the aggrieved person by the defendant.

6. On 30 June 2020, the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised her opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

The Aggrieved Person

7. The aggrieved person, aged 87 years old at the time of these events, had been a resident at Karadean Court, receiving hospital-level care, since 2009.

8. The aggrieved person had a number of health conditions, including a history of heart attack, atrial fibrillation,[1] Type II diabetes, hypertension,[2] stroke, hypothyroidism,[3] ischemic heart disease,[4] and vascular dementia.[5]

9. On 21 August 2016 the aggrieved person was transferred to Christchurch Hospital when attempts to administer antibiotics for a parotid gland obstruction were unsuccessful.

10. The aggrieved person passed away on 24 August 2016.

The Defendant

11. The defendant company owns and operates Karadean Court, providing rest home-level, hospital-level, respite and palliative care to up to 53 residents.

12. Karadean Court is contracted by Canterbury District Health Board to provide rest home- and hospital-level care to consumers in the Canterbury region.

13. Clinical leadership and support at Karadean Court was provided by the Clinical Services Manager whose role also entailed monitoring the

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[1] An irregular, rapid heartbeat.
[2] Abnormally high blood pressure.
[3] An underactive thyroid gland.
[4] Heart disease characterised by reduced blood flow to the heart.

provision of care to residents, and providing oversight of all resident clinical records to ensure they met the defendant organisation's requirements, including legislative requirements.

14. Medical practitioner care at Karadean Court is provided by a general practitioner (GP) who attends residents on site.

PARTICULARS RELATING TO THE AGGRIEVED PERSON

Diabetes management – blood glucose levels

15. The defendant's Diabetes Policy in place at the time of these events stated that if a resident had hypoglycaemia with a blood glucose level above 8 mmol/L, the resident was to be given insulin immediately and medical help obtained.

16. The aggrieved person's resident lifestyle plan[6] recorded that he was to "maintain [blood glucose levels] between 4 – 12 [mmol/L]". The health monitoring records stated that the aggrieved person's blood glucose levels were taken by staff "as needed". The aggrieved person had a yearly profile checks and six-monthly HbA1c blood tests.[7]

17. Between 12 August 2015 and 29 April 2016, staff recorded the aggrieved person's blood glucose levels on four occasions. On all occasions the level recorded was between 4 – 12 mmol/L, as indicated on his lifestyle plan.

18. Throughout July and August 2016, the aggrieved person experienced dehydration, diarrhoea and infection associated with an outbreak of norovirus at Karadean Court. Despite this, staff did not increase monitoring of the aggrieved person's blood glucose levels.

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[5] A common type of dementia caused by reduced blood flow to the brain.
[6] Dated 16 January 2013.
[7] A test to measure the amount of blood sugar attached to haemoglobin.

19. On 9 July 2016, staff recorded that the aggrieved person's blood glucose level was 14.8mmol/L. Despite this level being higher that the recommended range in his resident lifestyle plan, and contrary to the Diabetes Policy, the aggrieved person's elevated blood glucose level reading was not escalated to a medical practitioner, and follow up blood glucose level readings were not taken.

20. On 15 August 2016, the aggrieved person's blood glucose level was 25.7 mmol/L. The blood glucose level was recorded by a CAP student nurse.[8] Despite this level being significantly higher than the recommended range in the lifestyle plan, and contrary to the Diabetes Policy, the aggrieved person's elevated blood glucose level reading was not escalated to a senior staff member or medical practitioner, and follow up blood glucose level readings were not taken.

21. The defendant's Diabetes Policy did not outline the required frequency of blood glucose level testing. The regularity at which staff took the aggrieved person's blood glucose levels was inadequate, particularly when the aggrieved person was experiencing dehydration, diarrhoea and infection.

Diabetes management - podiatry

22. The aggrieved person's resident lifestyle plan[9] recorded that he was to be reviewed by a podiatrist if required. This was necessary due to the aggrieved person's Type II diabetes.

23. On 31 August and 9 November 2015, a podiatrist reviewed the aggrieved person. No concerns were identified.

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[8] Competency Assessment Programme. This is a programme for internationally-registered nurses who wish to obtain nursing registration in New Zealand.
[9] Dated 16 January 2013.

24. On 24 December 2015, a nurse recorded that the aggrieved person's right big toe was red and swollen. The Clinical Services Manager was told, who advised the nurse to inform the GP, due to concerns over infection and because the aggrieved person had diabetes.

25. The same day, a rural nurse from a medical centre reviewed the aggrieved person and prescribed an antibiotic, Epsom salt soaks, and a review with a podiatrist. Despite this recommendation, there is no record in the aggrieved person's clinical notes that a podiatry review was recommended, and none took place.

26. The infection care plan dated 5 January 2016 indicated that the aggrieved person's toe infection had resolved.

27. On 22 January 2016, a GP reviewed the aggrieved person due to concerns his right big toe was infected again. The GP diagnosed paronychia,[10] prescribed an antibiotic, and requested that a podiatrist review the aggrieved person at the next visit.

28. A podiatrist reviewed the aggrieved person one month later, on 22 February 2016.

29. A further podiatry appointment was scheduled for 23 May 2016, but the aggrieved person did not attend. No reason for the non-attendance was recorded.

30. The aggrieved person was seen again by the podiatrist on 4 July 2016. No further podiatric reviews are recorded for the aggrieved person during his time at Karadean Court.

[10] Inflammation of the skin around the toenail.

Delayed administration of medication

31. On 9 July 2016, after complaining of chest pains, the aggrieved person was transferred to Christchurch Hospital by ambulance, where he was diagnosed with NSTEMI.[11]

32. On 11 July 2016, the aggrieved person was discharged back to Karadean Court. On discharge the aggrieved person was prescribed a low dose (23.75mg daily) of metoprolol[12] in addition to his usual medications. The medication was administered to the aggrieved person that evening, at Karadean Court.

33. The aggrieved person was not administered metoprolol on the morning of 12 July 2016, as should have occurred.

34. Later that day, the aggrieved person experienced chest pains. His blood pressure was high, at 179/93 mmHg. It was noted that the aggrieved person had not been given metoprolol that morning. A rural nurse and the GP were consulted via telephone, and a verbal order was given to administer GTN spray[13] along with the missed dose of metoprolol.

35. The Clinical Services Manager did not complete an incident form reporting the delayed medication.

36. The aggrieved person's family was not informed he had experienced chest pains or of the delayed medication administration until the next day.

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[11] Non-ST-Elevation Myocardial Infarction. A type of heart attack.
[12] A beta blocker is used after a heart attach to prevent heart damage, heart failure or high blood pressure. It slows the heart rate, making it easier for the heart to pump blood around the body.
[13] Glyceryl trinitrate, used for rapid relief of angina.

37. The defendant has acknowledged that if the aggrieved person had not had chest pains on 12 July 2016, it is most likely the metoprolol dose which should have been administered that morning would have been missed.

Pressure area care

38. In October 2015, a Norton scale risk assessment ("Norton assessment")[14] of the aggrieved person indicated he was at medium risk of developing pressure sores. The aggrieved person's initial Norton assessment score was 18, recording: physical condition - 4 (out of 4), good, stable medical condition, appears healthy and well nourished; mental condition – 4 (out of 4), alert, oriented and aware of surroundings; activity – 4 (out of 4), abundant, up and about; mobility – 4 (out of 4), full, independent in moving; and incontinence 2 (out of 4) usually – urine, 3 – 6 episodes in 24 hours.

39. Between October 2015 and August 2016, further Norton assessments were undertaken in respect to the aggrieved person every three months. The aggrieved person's assessment under each of the five headings remained unchanged throughout the rest of his assessments despite deficits in his physical and mental condition, activity, mobility, and incontinence being recorded in his clinical notes and care plans.

40. In April 2016 it was recorded that a pressure-relieving mattress should be obtained for the aggrieved person. This did not occur.

41. In August 2016, the Clinical Service Manager requested an air mattress from the defendant. The defendant did not provide the air mattress to the aggrieved person.

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[14] The Norton assessment is a predictive took for assessing the risk of developing pressure areas. The assessment evaluates physical condition, mental condition, activity, mobility, and incontinence to give a score between 5 and 20.

Wound management

42. During the time the aggrieved person resided at Karadean Court he developed a sacral pressure wound (identified on 13 August 2016) and a pressure injury to his right foot (identified on 14 August 2016).

43. On several occasions, the aggrieved person's wounds were inaccurately recorded. For example:

    a. on 14 August 2016,[15] the sacral wound was documented in the progress notes as black and red with 50% necrosis. It is accepted that at this stage the wound was unstageable;[16]

    b. on 15 August 2016, the wound was documented in the progress notes as Stage II;

    c. on 14, 15, and 16 August 2016, the sacral wound was recorded in the soft tissue care plan as black with 40% to 50% necrotic tissue;

    d. on 16, 17, 18 and 20 August 2016, the sacral wound was recorded on the wound treatment charts as Stage II and described as superficial.

44. On 14 August 2016, a photograph of the pressure injury on the aggrieved person's right foot was taken by a staff member, on their personal mobile phone. Due to concerns about keeping a photograph taken on a mobile

[15] Recorded retrospectively on 15 August 2016.

[16] Pressure injuries are classified into six categories: Grade/Stage I – intact skin with non-blanchable redness of a localised area; Grade/Stage II – Partial-thickness loss of skin with exposed dermis. The wound bed is visible, pink or red, moist, and may also present as an intact or ruptured serum-filled blister; Grade/Stage III – Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible; Grade/Stage IV - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible; Unstageable: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Grade/Stage III or IV pressure injury would be revealed.

phone, the photograph was not uploaded to the aggrieved person's file, and was instead deleted.

45. When the aggrieved person was admitted to Christchurch Hospital on 21 August 2016, his sacral pressure injury was described as "huge" and in need of specialist wound care of surgical debridement. The aggrieved person's Norton assessments, soft tissue care plans, and progress notes failed to accurately reflect the serious nature of this wound.

Pain management

46. The defendant's Pain Management Policy provided that an assessment should be carried out for a resident who presented with acute or new pain, and that a short-term care plan or a long-term care plan be commenced and evaluated at least every three months. The policy noted that "the causative factors of pain are investigated by the [registered nurse] and GP as required" and that "regular liaising with the GP occurs to ensure effective pain control is achieved".

47. On 3 January 2016, a nurse documented that the aggrieved person's groin area was red, but that there was no pain present.

48. On 6 January 2016, it was recorded that the GP had prescribed Micreme[17] as required for redness to the aggrieved person's scrotum. It is not recorded whether the GP reviewed the aggrieved person in person.

49. On 26 January 2016, it was noted the aggrieved person had further episodes of infection on his groin or scrotum area which were managed by Micreme. There is no evidence of a further review by a GP of the aggrieved person's pain, or the redness to his groin and scrotum.

[17] A broad-spectrum anti-fungal and anti-inflammatory cream.

50. On multiple occasions during January and February 2016, the aggrieved person reported being in pain, in relation to the redness on his groin and scrotum. There is no indication the aggrieved person was offered or provided with any pain relief when he reported pain during this time.

51. On 27 February 2016, a pain monitoring form was commenced for reported scrotal pain and paracetamol was given.

52. While instances of pain (on a scale of 2 out of 5) were recorded on multiple occasions in August 2016 (related to dressing changes of the aggrieved person's sacral wound) these were not charted on a pain monitoring form and there is no record pain relief was offered or given.

Norovirus outbreak

53. On 12 August 2016, the aggrieved person vomited and had an episode of diarrhoea. He was placed in isolation due to an outbreak of norovirus at Karadean Court. A short term care plan was commenced to prevent dehydration, directing staff to monitor the aggrieved person's fluid input and output, and encourage fluid intake.

54. On 13 and 14 August 2016, it was recorded that the aggrieved person had multiple episodes of loose bowel motions and was not eating or drinking well.

55. On 14 August 2016, the aggrieved person's wife was notified that he was not eating or drinking well. The aggrieved person's family was not advised that he was suffering the symptoms of norovirus.

56. On 15 August 2016, the aggrieved person was seen by a GP due to his norovirus symptoms of vomiting and diarrohea. The GP recorded her impression of gastroenteritis and dehydration and strongly encouraged

staff to push oral rehydration or administer subcutaneous fluids (via an intravenous line) if the aggrieved person did not consume a sufficient amount.

57. The aggrieved person's wife was advised of the GP's visit. The aggrieved person's family was not told about the norovirus outbreak.

58. The aggrieved person's records show there was a gap in managing his symptoms of norovirus. Staff failed to ensure that adequate fluid balance was maintained and that regular blood glucose observations were done during this time.

Continence issues

59. On 17 July 2015, the aggrieved person's continence assessment was commenced. It recorded that he was incontinent of urine but continent of faeces and required assistance from staff with his toileting regime, including before meals and during the night.

60. Between August 2015 and August 2016, there were 33 documented occasions on which the aggrieved person was incontinent of urine and faeces.

61. Also between August 2015 and August 2016, there were multiple reviews of the aggrieved person's continence assessment, which failed to recognise the decrease in his continence:

    a. on 26 January 2016, a continence assessment review noted that the aggrieved person was incontinent during the day and night, but the outcome of the review was unchanged from the previous July 2015 review;

b. on 28 April 2016, a change was recorded in the continence assessment, in relation to the aggrieved person's toileting regime and it was recorded that staff would assist the aggrieved person with toileting after breakfast and continue to review him every two to three hours overnight. No mention was made of the aggrieved person's faecal incontinence in the continence assessment despite this being noted on his new resident lifestyle plan also completed that day;

c. on 2 August 2016, the continence review was reviewed and the outcome remained unchanged, noting that the aggrieved person required assistance with toileting after breakfast and every two to three hours during the night, and that he continued to use continence products. The section entitled "remains continent" was left blank. On the same day, the same staff member recorded in the aggrieved person's resident life plan that he continued to be toileted every three to four hours and as required.

62. No continence review was conducted following the August 2016 norovirus outbreak.

Consultation with a GP

63. GP consultations of the aggrieved person met the Ministry of Health's three-monthly review requirements for when a patient is in a stable condition and, on some occasions, staff consulted appropriately in relation to changes in the aggrieved person's health.

64. However, between February 2016 and August 2016, there were several occasions when the aggrieved person's health issues were not escalated to a GP, when this should have occurred:

a. while the GP's advice was sought on 6 January 2016 in relation to the aggrieved person's scrotal redness and pain, further advice was not sought during subsequent consultations, despite the redness and pain continuing at those times. This was contrary to the defendant's Pain Management Policy;

b. in July and August 2016, the aggrieved person returned two high blood glucose levels, neither of which was escalated to a GP. This was contrary to the defendant's Diabetes Policy;

c. while the aggrieved person was reviewed by a GP on 15 August 2016 in relation to faecal incontinence caused by norovirus, the aggrieved person's frequent and ongoing faecal incontinence was not reported to a GP; and

d. no advice was sought from the GP in relation to the aggrieved person's pressure wounds.

Staffing

65. At the time of the events set out in this agreed summary of facts, the skill mix on site at Karadean Court was lacking in competent registered nurses. At that time, over half of the registered nurses required support in their roles and there were only two registered nurses who could provide that support (being the Clinical Service Manager and the senior registered nurse).

Transfer to hospital and poor documentation

66. On 21 August 2016, the aggrieved person was noted to have a swollen cheek and inside of mouth, and elevated temperature. He was diagnosed

with a suspected parotid gland[18] infection and prescribed antibiotics. That evening, after two unsuccessful attempts to administer him oral antibiotics, the aggrieved person was transferred to Christchurch Hospital.

67. A registered nurse at Karadean Court prepared a Transfer Referral Report which accompanied the aggrieved person to hospital. This report failed to record the aggrieved person's: facial swelling; suspected parotid gland infection; sacral wound; foot pressure area; and scrotal redness and pain, each of which were factors highly relevant to his health status and nursing care on transfer to the hospital.

68. The aggrieved person was admitted to the Emergency Department and diagnosed with parotitis[19] and sepsis. When he was transferred to a ward it was noted that he had "large pressure sores over his sacrum, [and] necrotic tissue".

69. The Transfer Referral Report did not comply with the defendant's Clinical Records Documentation Policy, which stated that: "entries must be factual, accurate, legible and complete" and that "[t]he Clinical Record is a legal document" and "must provide clear evidence of care planning, decisions made, care delivered, information shared, problems identified and actions taken to rectify them".

SUBSEQUENT EVENTS

70. Following his admission to the Emergency Department at Christchurch Hospital, the aggrieved person was admitted to Ward 27.

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[18] Salivary gland.
[19] A panful swelling of the salivary glands, often caused by bacterial infection.

71. On 24 August 2016, the aggrieved person died in Christchurch Hospital as a result of septicaemia[20] and facial cellulitis.[21]

EXPERT ADVICE

72. RN Rachel Parmee provided expert advice to the HDC. RN Parmee found that the defendant had departed from accepted standards in relation to the following aspects of the care it provided to the aggrieved person.

The management and treatment of the aggrieved person's pressure wounds

73. RN Parmee confirms that care of pressure areas is at the foundation of assessment and care of the elderly in any setting, particularly hospital level residential care. An acceptable standard is that pressure areas should first and foremost be prevented through appropriate nursing care including positioning and in this case management of incontinence.

74. She considered it was clear from the progress notes and pressure and assessment records that urinary and faecal incontinence was contributing to the status of the aggrieved person's skin integrity.

75. The Norton assessments were carried out every three months between 21 October 2015 and 2 August 2016. It was noted there was no change to the assessment score over this time. There are discrepancies between this assessment and the progress notes and care plans created during this time. Deficits in the aggrieved person's physical condition, mental condition, activity, mobility and continence noted in the progress notes and care plans were not recorded on the Norton assessment.

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[20] An infection of the blood.

[21] A bacterial infection of the skin and underlying tissues.

76. There was a lack of understanding of the importance of photographs in monitoring the progress of a wound. Chronological photographs of wounds are an expected practice in wound management. Given the perceived inaccuracy of documentation describing the wound in this case, photographs would have been useful.

77. The aggrieved person's sacral wound was poorly managed both in terms of assessment documentation and monitoring. The GP was not kept updated with the progress of the aggrieved person's wound. Further, the aggrieved person was not referred to a Wound Care Specialist, which would have been appropriate given the lack of evidence of healing by the time of the aggrieved person's admission to Christchurch Hospital.

78. The aggrieved person was never provided with a pressure relieving air mattress.

Management of pain and redness on the aggrieved person's scrotum and buttocks

79. RN Parmee confirms that in cases of incontinence (particularly both urinary and faecal) it is of the utmost importance that daily observations and care of affected skin areas is carried out.

80. There is little evidence of management of the pain the aggrieved person was experiencing, management of the redness to the GP, or a short term care plan in place.

81. There were numerous (at least 31) records of observation of the redness and pain on the aggrieved person's scrotum and backside, but little mention of a plan to treat the redness or prevent further occurrence other

than 'keep clean and dry' being recorded and the use of Cavilon[22] spray or cream.

Management of the aggrieved person's incontinence, dehydration, diabetes and diarrhoea

82. RN Parmee confirms that continence care, including diarrhoea, and hydration are expected basic requirements in the care of older adults in a hospital level setting. These cares should be provided based on regular assessments leading to a documented care plan with regular evaluation, and additional evaluations when there are changes to the status of the patient. Continence care includes the implementation of an appropriate, documented toileting regime which is adhered to by all involved in the client's care, along with the use of appropriate continence products with regular evaluation of their effectiveness.

83. While there was regular documentation of incidents of incontinence, there was little evidence of interventions and evaluations of these.

84. A continence report dated 17 July 2015 indicated the aggrieved person was not faecally incontinent. Three reviews documented between January and August 2016 indicate that this initial assessment was 'unchanged'. It is clear from the extensive list of episodes of faecal incontinence found in the progress notes that this assessment was inaccurate and indicates that there was no review of the appropriateness of the toileting regime or incontinence products.

85. The interventions listed on the short term care plan dated 28 April 2016 did not include a toileting programme and stated "administer laxatives or

[22] Cavilon spray provides a barrier over broken, tender or irritated skin without stinging. It may be used on superficial skin trauma (no more than 0.1mm deep) as a primary dressing. It is not to be used as the only covering on full or partial thickness wounds or infected areas of skin.

medication for loose bowel motions as per medication chart". There is no evidence in medical consultations that these medications were ever reviewed in light of the frequent episodes of faecal incontinence.

86. The effect of the lack of appropriate interventions on the aggrieved person included the development of red and painful skin, a large pressure area, and dehydration.

87. RN Parmee's view is that basic care of a client with diabetes includes monitoring blood glucose levels, particularly at times when nutrition is compromised, such as during periods of dehydration, decreased appetite and diarrhoea.

88. The aggrieved person's care plan stated that his blood glucose level should be maintained between 4 – 12 mmol/L and be taken by staff as required. The readings of 14.8 mmol/L on 9 July 2016, and 25.7 mmol/L on 15 August 2016, fell outside this range and needed to be followed up. These readings were gathered during a time when nutrition was compromised. The high reading indicates that the aggrieved person was experiencing significant stress related to his diarrohea and dehydration.

89. RN Parmee also confirms foot care is significant in the care of clients with diabetes with the potential for diabetic neuropathy. The presence of a heel (or foot) pressure area and infected toe are evidence that the aggrieved person's feet were not adequately monitored or cared for.

Norovirus outbreak

90. The ongoing care of the aggrieved person was compromised in terms of ensuring an adequate fluid balance was maintained. The regularity of blood glucose monitoring during this time was inadequate.

91. There is no record that the aggrieved person's next of kin was advised of the norovirus outbreak.

Medication administration error

92. RN Parmee confirms the standard practice around medication administration errors is that all errors are reported using the institution's incident reporting process. This would include a missed administration of medication.

93. The Clinical Manager was appropriately advised the incident (regarding metoprolol, at [31]-[34]) had occurred, but made the decision not to report the incident, which was a highly significant departure.

Frequency of GP consultations

94. The Ministry of Health requires that clients are reviewed by a GP every three months when in a stable condition and more regularly when there is a change in health status.

95. While there were an appropriate number of consultations with the GP and the GP responded appropriately when consulted outside of the three monthly review requirements, there were situations when the GP was not notified by nursing staff of events which would be expected to have GP input, such as advice on the management of faecal incontinence, the presence of foot and sacral pressure areas, pain and redness of the scrotal area, and the medication error.

Standard of clinical documentation

96. RN Parmee believes the accepted standard of clinical documentation requires comprehensive, accurate assessments using recognised assessment tools, care plans (both long and short term) derived from the

findings of assessments, and clearly documented interventions including frequency of monitoring and intervention. Referrals should include all relevant information using recognised formats.

97. The notes that accompanied the aggrieved person to Christchurch Hospital included a list of medical diagnoses and activities for daily living information including continence. There was no mention to the aggrieved person's facial swelling, sacral wound, scrotal redness, and pain or foot pressure area in the section headed 'pertinent history'.

DEFENDANT'S RESPONSE TO THE COMPLAINT

98. The defendant accepts that there were deficiencies in the care that its staff provided to the aggrieved person and that it has ultimate responsibility for the care that was provided.

99. Following the events set out in this agreed summary of facts, the defendant made the following changes:

    a. improved the skill mix within the nursing pool by increasing the number of proficient registered nurses on staff;

    b. mandated reporting of all pressure injuries to the National Office;

    c. designated oversight of wound management for all residents to a National Clinical Coach;

    d. provided support to clinical managers by way of a regional quality nurse advisor;

    e. introduced regular audits of clinical documentation (including care plans) by an audit and compliance manager;

f. undertook a review of its Pressure Injury Prevention and Management Policy;

g. updated its Cause and Description of Pressure Injuries document to reflect the use of its Short Term Plan for pressure injuries;

h. reviewed its Management of Diabetes Policy and added Blood Glucose Monitoring for Type II diabetics;

i. reviewed its Deterioration in Health Status Procedure to show that short term care plans are to be instigated if a resident is unwell and is to remain under the management of the facility;

j. revised its Clinical Communication Tool to include a map of the person, to locate pressure injuries, skin tears, and bruising when making a referral;

k. revised its Pain Management Policy to place emphasis on pain monitoring and short-term care planning (for acute pain); and

l. developed a Hydration Plan.

100. Karadean Court underwent a certification audit in 2017, and a surveillance audit in 2019. The defendant reports these audits found no evidence of the recurring issues found in 2016, which are the subject of this agreed summary of facts.

BREACH OF THE CODE

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

102. The defendant had a duty to provide the aggrieved person services with reasonable care and skill, and was responsible for the actions of its staff at

Karadean Court. The defendant also had a duty to ensure that its staff provided services that ensured continuity of care, and complied with the New Zealand Health and Disability Sector Standards.

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

104. The defendant had the ultimate responsibility to ensure the aggrieved person received care that was of an appropriate standard and complied with the Code.

105. The defendant accepts that it failed in that responsibility and breached Right 4(1) of the Code. In particular:

    a. continence reviews and care plans were inadequate and did not reflect the aggrieved person's continence needs or guide staff in that care. Multiple staff recorded that the aggrieved person had frequent episodes of incontinence and, despite this, there was no escalation to a GP;

    b. care plans did not record how often the aggrieved person required podiatric reviews;

    c. the frequency of the aggrieved person's podiatric reviews was inadequate, and the documentation about the reviews undertaken was also inadequate;

    d. between July and August 2016, two high blood glucose level readings were recorded, but staff did not escalate this to a GP or repeat the readings, which was a departure from the Diabetes Policy;

e. in August 2016, despite the fact the aggrieved person was experiencing acute illness caused by norovirus, staff did not monitor his blood glucose levels regularly;

f. staff did not utilise pain assessment tools appropriately to assess the aggrieved person's pain and develop appropriate care plans to manage his pain adequately;

g. despite multiple reports of pain during the aggrieved person's admission, GP advice was sought on only one occasion;

h. the Norton assessments undertaken were inaccurate and did not reflect the changes in the aggrieved person's health as recorded in the clinical notes;

i. despite the need for a pressure-relieving air mattress being indicated in April 2016, the aggrieved person was not provided with one during his residency;

j. the management of the aggrieved person's pressure injuries by the defendant's staff was extremely poor;

k. the management and record keeping of the aggrieved person's wound care was also very poor: descriptions of the aggrieved person's wound care, made by various staff, were inaccurate and inconsistent; the monitoring of the wounds was inadequate; and neither GP nor specialist advice was sought in a timely manner;

l. there was a lack of clear and accurate documentation of the aggrieved person's health status by multiple staff, in particular regarding his wound care documentation and in the transfer referral report to the hospital;

m. the aggrieved person's faecal incontinence, foot and sacral pressure areas, and pain and redness of his scrotal area were not well managed, and staff should have sought GP advice on these issues; and

n. there was a paucity of registered nurses available to provide oversight to junior staff, and a lack of leadership over staff.

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Kerrin Eckersley
Director of Proceedings

Date:

I, Benjamin Paul Unger, agree that the facts set out in this Agreed Summary of Facts are true and correct.

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Benjamin Paul Unger
Director
For or on behalf of
The Ultimate Care Group Limited

Date: