(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF 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 **[2017] NZHRRT 55**

	Reference No. HRRT 065/2017
UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**BUPA CARE SERVICES NZ LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines QC, Chairperson
Dr SJ Hickey MNZM, Member
Mr BK Neeson JP, Member

REPRESENTATION:
Ms K Eckersley, Acting Director of Proceedings
Ms W Aldred for defendant

DATE OF DECISION: 15 December 2017

DECISION OF TRIBUNAL[1]

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[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 11 December 2017.

[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:

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[1] [This decision is to be cited as: *Director of Proceedings v Bupa Care Services NZ Ltd* [2017] NZHRRT 55.]

[2.1] A Consent Memorandum dated 15 November 2017.

[2.2] An Agreed Summary of Facts, a redacted 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, a signed copy of which is filed with this memorandum, together with an anonymised copy.
> 2. The plaintiff requests that the Tribunal exercises its jurisdiction and issues:
>   (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
>   (b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter [redacted].
> 3. In relation to the declaration being sought in paragraph 2(a) above, the parties respectfully refer to the agreed summary of facts. 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 anonymised agreed summary of facts be published by the Tribunal as an addendum to the decision.
> 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 2(b).
> 5. The defendant does not seek any order prohibiting publication of the defendant's name.
> 6. In the statement of claim the plaintiff also sought the following relief:
>   (a) damages pursuant to s 57(1); and
>   (b) costs.
> 7. 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.

[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 2(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 and any other details which might lead to the identification of the aggrieved person. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Mr RPG Haines QC	**Dr SJ Hickey MNZM**	**Mr BK Neeson JP**
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 15 December 2017.

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 **BUPA CARE SERVICES NZ LIMITED**, a duly registered company having its registered office at Level 5 Bupa House, 5-7 Kingdon Street, Newmarket, Auckland

Defendant

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

Kerrin Eckersley – Acting Director of Proceedings

AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by section 15 of the Health and Disability Commissioner Act 1994 ("the Act").
2. The "aggrieved person" is the consumer, Ms A (deceased).
3. At all material times, the defendant was a registered company which owned and operated [X] Rest Home and Hospital in [X].
4. At all material times, the defendant was a healthcare provider and/or disability services provider within the meaning of s 3 of the Act, and was providing health services and/or disability services to the aggrieved person.
5. In [Month] 20[X] the Coroner referred the aggrieved person's death to the Health and Disability Commissioner ("HDC") for consideration of the care provided to the aggrieved person in [Month] 20[X] while she was a resident at [X].
6. On 30 June 2017 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 [X] years, was a resident at [X] in 20[X]. She received private hospital-level care. She had transferred to [X] in [Month] 20[X] from [X] to be closer to family.

8. The aggrieved person suffered from debilitating progressive multiple sclerosis ("MS")[1] and, as a result, was paraplegic, largely bed bound, blind in her left eye, and required a long-term urinary catheter. She was a type 2 diabetic dependent on insulin, and had a cardiac pacemaker. She also suffered from syndrome of inappropriate anti-diuretic hormone secretion ("SIADH")[2] and depression.

9. While the aggrieved person required complete assistance with her personal cares, she was able to, and did, express preferences for her diet and regarding her cares.

10. On 24 [Month] 20[X], the aggrieved person died at [X] Hospital from septic shock due to necrotising fasciitis caused by an infected sacral pressure ulcer which had developed at the beginning of [Month] while she was a resident at [X].

The Defendant

11. The defendant is a company registered with the New Zealand Companies Office, having its registered office at Level 5 Bupa House, 5-7 Kingdon Street, Newmarket, Auckland. It owns and operates rest home hospitals and retirement villages in New Zealand.

12. The defendant owns and operates [X], a facility which provides hospital and rest home level care. In 20[X] [X] achieved a three-year certification from the Ministry of Health. At the time in question, [X]'s hospital wing had 22 beds and was supervised by a Clinical Manager ("CM"), and a Unit Coordinator ("UC"), both of whom were registered nurses. On

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[1] A chronic degenerative disease of the central nervous system marked by patchy destruction of the myelin that surrounds and insulates nerve fibres. It is manifested by neural and muscular impairments, including spastic weakness in the limbs, local sensory losses, and bladder dysfunction.

[2] Characterised by excessive release of the antidiuretic hormone, resulting in an increase in water/fluid within the body.

every shift, a registered nurse ("RN") was on duty, together with two caregivers.

13. A visiting general practitioner ("GP") made rounds at [X] twice weekly. The rounds alternated between the hospital and the rest home wings, and nursing staff could request a GP visit for any patient by writing in the GP's diary. Nursing staff could also arrange referrals for external wound specialist nurse review from the District Health Board.

EVENTS OF [MONTH] 20[X]

Management of sacral pressure wound

14. Shortly after her admission to [X] in [Month] 20[X], the aggrieved person was placed on an air mattress. It was recorded in her Care Plan that she was to be turned two-hourly in order to prevent the development of pressure sores. On 8 [Month] 20[X] the mattress was removed at the aggrieved person's request, as it was causing her discomfort. In [Month], the aggrieved person also asked staff not to disturb her sleep at night by turning her two-hourly unless she asked them to do so.

Discovery of sacral pressure wound

15. On the evening of 2 [Month] 20[X], a caregiver discovered a pressure wound on the aggrieved person's sacrum. The caregiver informed the RN on duty and completed an incident form. The RN recorded in the aggrieved person's progress notes:

> "The pressure injury noted on her sacral area extending down to buttocks is a Grade 1 pressure sore,[3] non-blanchable redness ... skin intact ... [w]ound noted to be 12 cm in length and 16 cm in width, not in pain on area when doing the wound care. [The aggrieved person

[3] The "Waterlow" grading system has four recognised grades of pressure wounds. Grade 1, the least serious, refers to discolouration of intact skin not affected by light finger pressure (non-blanching erythema).

is] aware of the need to be turned on her sides every 2-hourly, instructed her to lie on her back only during meals."

16. The RN cleaned the area and applied a protective dressing. She moved the aggrieved person onto her side in bed and advised her to stay off her bottom.

17. The RN completed a Short-Term Care Plan[4] and Wound Initial Assessment and Plan, which included a Wound Management Plan section, in accordance with the defendant's policy entitled "Wounds — Management of". The Wound Initial Assessment and Plan recorded, in particular: "Monitor healing process of wound. May need to review Wound Management Plan if wound is deteriorating or unchanging." The Wound Management Plan directed that the dressing on the aggrieved person's pressure wound be replaced every 5–7 days or as needed.

18. On 3 [Month] 20[X], the GP reviewed the aggrieved person for an eye disturbance and hallucinations. His impression was that these symptoms were a result of exacerbation of her MS. Nursing staff did not advise the GP of the pressure wound.

19. On 3 [Month], the UC and the CM discussed with the aggrieved person the management of her pressure wound. The aggrieved person declined the use of an air mattress because she found it uncomfortable. She agreed to be turned every two hours during the day whilst awake, but requested not to have her sleep disturbed.

20. On 4 [Month] 20[X], nursing staff commenced a Wound Evaluation Chart ("evaluation chart") to record observations about the wound, including

[4] Which included the need for two-hourly turns and for the aggrieved person to remain on her back only for meal times.

size, condition, margins, presence of infection, exudate, and a general evaluation of the aggrieved person's pressure wound.

7 [Month] 20[X]

21. On 7 [Month] 20[X] an RN updated the aggrieved person's risk assessments. Her Braden Scale score[5] identified her potential risk of pressure injury as 14 (moderate risk). The RN also completed a mini nutritional assessment ("MNA"), recording the aggrieved person as "malnourished". The RN did not take any further action in response to these identified risks.

22. According to the post-mortem report provided to the Coroner, insulin dependent diabetes mellitus is a risk factor for infection.

9 [Month] 20[X]

23. On 9 [Month] 20[X], the GP reviewed the aggrieved person's pressure wound with the UC and noted redness and a dusky blue appearance to the skin. He noted that the aggrieved person's weight had increased to 58kg (admission weight was 54kg) and her blood pressure (120/88), temperature (36.3°C) and pulse (70 beats per minute) taken on 4 [Month] 20[X] were normal. The aggrieved person's blood sugar levels were stable (8.7). The GP did not order blood tests because he did not consider the aggrieved person to be malnourished, and he did not alter her charted prescription or "as required" medications. Following this review, the aggrieved person agreed to the use of the air mattress, which was placed on her bed. The GP considered that with two-hourly turns, the use of the air mattress, and good nursing care, the pressure wound should heal.

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[5] The Braden Scale is a predictive tool for assessing risk of developing a pressure injury. A score of less than 9 indicates severe risk, high risk 10–12, moderate risk 13–14, and mild risk 15–18.

24. At 10pm that night a caregiver recorded: "[V]ery red, broken skin, black spots on either side. RN notified ..." The RN on duty noted in the evaluation chart that the wound was deteriorating with a low level of exudate (discharge) where previously there was none. No change was made to the Wound Management Plan.

10 [Month] 20[X]

25. The nursing notes record that the aggrieved person was upset during the day due to a personal matter.

26. On 10 [Month] 20[X], the UC completed a wound assessment and recorded in the evaluation chart that it had deteriorated, with tissue that was 5% necrotic (black), 15% sloughy (yellow), 20% granulating tissue,[6] and 60% epithelializing (red or deep pink). She also recorded that there was a slight odour and a low amount of exudate. No change was made to the Wound Management Plan.

27. The nursing notes record that the aggrieved person was sleepy at lunch time.

28. Again, on 12 [Month] 20[X] the nursing notes record the aggrieved person was too sleepy to eat lunch.

13 [Month] 20[X]

29. On 13 [Month] 20[X], the RN on duty updated the wound evaluation chart, observing "slight deterioration" of the pressure wound and recording tissue that was 5% necrotic, 20% sloughy, 20% granulating, 50% epithelialising,[7] odorous, and with a low level of yellow and red

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[6] New connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process.
[7] It is noted that the percentages as recorded do not equal 100%.

exudate. The RN changed the dressing, applied intrasite gel to help debride the wound from the slough and necrotic tissues and recorded this on the evaluation chart, but no change was made to the Wound Management Plan.

15 [Month] 20[X]

30. On 15 [Month] 20[X], the pressure wound had again deteriorated. The RN on duty noted the pressure sore "looks really bad" and recorded a moderate amount of yellow exudate and a very foul smelly yellowish pus seen around the area and the skin was peeling off from the site. The tissue was noted as 10% necrotic, 40% sloughy, 10% granulating, and 40% epithelialising. In addition, the RN recorded that the wound was causing pain. She cleaned and re-dressed the wound, informed the next RN on duty, and recorded her observations in the Manager's Report Book, which was reviewed and signed by both the Facility Manager and the CM following each 24-hour period.

31. The nursing notes record the aggrieved person was sleeping most of the day and did not eat breakfast or lunch.

16 [Month] 20[X]

32. During this period, staff observed that the aggrieved person appeared upset about some personal news she had received.

33. On 16 [Month] 20[X], a multi-disciplinary review ("MDR") meeting took place to review the aggrieved person's care.

34. The MDR meeting minutes record that the aggrieved person had a "pressure area" on her sacrum, that she liked to choose her own food and amount, and that her weight had increased by 3kg within three months.

The RN present recorded that the aggrieved person could be turned two-hourly during the day, but that she did not want to be disturbed during the night except for when providing her sleeping pill at 10pm.

35. At the MDR, no concerns about the sacral wound were discussed, and the focus was on a personal matter affecting the aggrieved person. No action was taken to seek further medical review or amend the Wound Management Plan.

36. On 16 [Month], the GP attended [X] for his usual rounds but the aggrieved person was not included in the list of patients to be seen. He made enquiries with staff as to her condition, and was advised that there were no concerns about her.

37. Also on this day, the aggrieved person's air mattress was found to be not full as the aggrieved person had asked for the air to be adjusted when she was uncomfortable.

17 [Month] 20[X] – nutritional intake declines

38. From 17 [Month] 20[X] onwards, the aggrieved person was consistently noted to be quieter, with a low mood, and eating less and, at times, refusing to be turned. Recorded blood sugar levels ("BSL") were elevated from baseline trend. Staff made regular entries in the Manager's Report Book about the aggrieved person's condition, indicating general deterioration.

39. At the end of her shift on 17 [Month], the UC recorded in the Manager's Report Book that the aggrieved person was "very depressed", had eaten well at breakfast but declined everything at lunch.

40. Later, the RN on duty recorded that the pressure wound had further deteriorated, 10% necrotic, an increase in sloughy tissue to 50% (and a

corresponding 10% decrease in epithelialising tissue). It remained odorous, with a moderate amount of yellow exudate, and the wound margins were noted to be slightly inflamed. The RN changed the Wound Management Plan by amending the dressing from "Warm saline + Replicare Ultra" to "Warm saline + Allevyn", and amending the frequency that the dressing was to be changed from "5–7 days or as needed" to "6–7 days or as needed". All other aspects of the Wound Management Plan were unchanged.

18-20 [Month] 20[X]

41. The progress notes during this period reflect that the aggrieved person was continuing to eat and drink very little, was less active, had low mood, and was not talking much.

42. There was no referral for GP assessment on 18 [Month] 20[X] despite the aggrieved person being a diabetic, immobile resident with a deteriorating sacral pressure injury, who was also withdrawn, upset, and with a poor dietary intake.

43. On 20 [Month] 20[X], the RN on duty recorded that the aggrieved person was not drinking well and her condition of health was deteriorating. Later that night the RN checked the aggrieved person's vital signs (which were normal) as she found the aggrieved person's body was "too cold". The aggrieved person's oxygen saturation level was low at 90%. The observations did not include her respiratory rate.

44. By 20 [Month] 20[X], nursing staff noted the aggrieved person's deteriorating general condition and diminished appetite but sought no medical advice.

45. Staff attributed the aggrieved person's decreased appetite and low mood to the aggrieved person being upset about a personal matter.

21 [Month] 20[X]

46. The RN on night duty conducted regular visual checks on the aggrieved person through the early hours of the morning, but did not wake her. The RN recorded:

> "On appearance (she is breathing). She is looking too much deteriorated. The light in her room has [been] turned on throughout the night to check on her regularly. She did not ask to turn it off either. She is just accepting all the things now at this stage. May be because she is sleeping and she doesn't know that the lights are on."

47. At 6.40am the RN recorded that the aggrieved person appeared confused and was experiencing visual hallucinations. The RN noted that she had not provided the aggrieved person with zopiclone (a sleeping tablet – see paragraph 60 below) and tramadol (pain relief) when requested at 6am, and that the aggrieved person "already appeared to be low and overdosed."

48. During handover, the night nurse explained to the RN coming on duty that the aggrieved person remained quite depressed, she was refusing food, fluid and cares, and her blood sugar levels were increasing. The aggrieved person was not responding well and her condition was very poor.

49. The RN on duty during the day evaluated the pressure wound and recorded in the evaluation chart a further deterioration, with now 20% necrotic tissue and a corresponding 10% decrease in sloughy tissue. There was a moderate amount of odorous yellow and red exudate, and

the wound margins were noted to be macerated.[8] In addition, the aggrieved person continued to experience pain from the pressure wound. The RN cleaned and re-dressed the wound, but made no change to the wound dressing section of the Wound Management Plan.

22 [Month] 20[X]

50. On the evening of 22 [Month] 20[X], the RN on duty noted the aggrieved person's lack of responsiveness. While she ate ice cream for dinner she would not open her mouth for fluids or medication. The RN noted the aggrieved person had redness measuring 5cm in width and 6cm in length on the left-hand side of her neck which she handed over to incoming staff to monitor.

23 [Month] 20[X]

51. At 1.25am on 23 [Month], the RN on duty noticed that the aggrieved person was awake, but not responding to questions verbally or with gestures. The RN completed a wound assessment and recorded that hardened skin had formed on her left buttock near the wound. The colour on the hardened skin turned light bluish, was about 18cm in diameter near the area with the pressure sore. She also noted the aggrieved person's lower and upper extremities were pale. A capillary nail refill test[9] was performed on her lower and upper nails, taking six seconds for colour to return. It was also recorded that the aggrieved person was not opening her mouth for mouth care using a swab. The RN recorded that the wound size was still the same but there was the presence of very foul smelly exudate of yellowish colour, moderate in amount on the old dressing. She recorded that the wound had

[8] Softened or broken down.

deteriorated 30% necrotic tissue, macerated margins, and advised the incoming RN that the aggrieved person was not responsive and that her wound was getting worse.

52. At around 9am, with the help of a caregiver, the UC assisted the aggrieved person to the shower. She observed that the aggrieved person was very unwell, just nodding or shaking her head. The UC checked the aggrieved person's observations and noted her temperature was high. Her blood sugar level remained high (19.1) even after her morning dose of insulin and her skin looked jaundiced.

53. The UC asked an RN to re-do the dressing on the aggrieved person's pressure wound while she went to see the Facility Manager to discuss her observations and her plan to request a GP visit, with which the Facility Manager agreed.

54. At 11am the CM was informed of the aggrieved person's condition and went to see her. She noted that she spoke to the aggrieved person, but the aggrieved person did not respond. The CM recorded that she directed that the GP be contacted and that the aggrieved person's observations and neurological observations be taken.

55. At 1.25pm the UC recorded the aggrieved person's vital signs on a Neurological Observation Sheet. The aggrieved person was non-responsive with a temperature of around 38.9°C, oxygen saturation 93%, pulse 49 beats per minute, blood pressure (BP) 80/50mmHg, and respiratory rate (RR) 45 breaths per minute. The wound was looking "necrotic". She faxed the GP to come and visit, recording a Grade 2

[9] The "capillary nail refill test" is a test done on the nail beds to monitor dehydration and the amount of blood flow to tissue. If there is good blood flow to the nail bed, a pink colour should return in less than two seconds after pressure is removed.

pressure sore.[10] The aggrieved person's observations were recorded again at 2.45pm, by which time her respiratory rate had decreased to around 42.

56. At 3pm the UC telephoned the Medical Centre to follow up on the fax, and was told that it had been forwarded to the on-call GP. The GP rang back advising them to send the aggrieved person to hospital.

57. An ambulance was called, arriving at [X] at 3.20pm. IV fluids were commenced and, at 3.45pm, the aggrieved person was transferred to [X] Hospital.

Admission to hospital

58. That evening, the aggrieved person was transferred from [X] Hospital to [X] Hospital, owing to a presumed diagnosis of sepsis due to necrotising fasciitis caused by an infected sacral pressure ulcer. In the early hours of the following morning, the aggrieved person underwent surgical debridement. Postoperatively she was managed in the intensive care unit but, despite maximum inotropic support[11] and ventilation, her condition became unsupportable and she died at 8.26am on 24 [Month] 20[X].

59. Medical reports provided to the Coroner by the Consultant General Surgeon involved with the aggrieved person's care at [X] Hospital concluded that:

a. the ulcer could have been prevented with expert nursing care of a wheelchair bound patient;

b. medical/surgical attention would have been appropriate to manage the ulcer as soon as it was noticed;

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[10] Grade 2 refers to partial-thickness skin loss involving the epidermis (outer layer of the skin) and/or the dermis (second layer of the skin), and presents as an abrasion or clear blister.
[11] Stabilisation of circulation and oxygen supply.

c. optimal and timely care of the ulcer might have prevented the complication of severe sepsis occurring and finally leading to death.

Zopiclone administration

60. Prior to her transfer to [X] in [Month] 20[X], the aggrieved person had been prescribed zopiclone 7.5mg (a sleeping tablet)[12] for insomnia to be taken at 9pm before retiring. From [Month] 20[X], her GP also charted an additional dose of 'as required' ("PRN") zopiclone, to be administered at night at her request.[13] On occasions during [Month] and [Month] 20[X], the second dose was administered at the aggrieved person's request between 2am and sometimes as late as 6.30am, causing her daytime sleepiness and associated reduced appetite and nutrition.

61. During [Month] 20[X], at the aggrieved person's request, zopiclone PRN continued to be administered to her, six times after 3am and, on 21 [Month] 20[X], at 2pm in the afternoon. The RNs documented this in the Manager's Report Book.

62. In particular, Zopiclone PRN was administered to the aggrieved person after 3am on 10, 12, 15 and 20 [Month] 20[X] after her sacral wound had begun deteriorating, again causing her daytime sleepiness and associated reduced appetite and nutrition.

63. The aggrieved person's requests for zopiclone were not discussed at the MDR review meeting on 16 [Month].

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[12] A short-acting hypnotic agent used for treatment of transient, short-term and chronic insomnia in adult. It should be used at the lowest effective dose, taken in a single intake shortly before retiring and not be re-administered during the same night, and used for a maximum of 2-4 weeks. The recommended dose should not be exceeded. It is not recommended for long term use (i.e. periods of more than 4 weeks). The pharmacological profile of zopiclone is similar to that of the benzodiazepines. Prolonged use may lead to the development of physical and psychological dependence. Other psychiatric and paradoxical reactions like restlessness, agitation, irritability, aggression, delusion, anger, nightmares, hallucinations, inappropriate behaviour and other adverse behavioural effects.

[13] The GP's intention was for zopiclone to be administered between 9pm and 11pm and a further dose only if required later in the evening or before 3am.

EXPERT NURSING ADVICE

64. RN Dawn Carey, who has a Post Graduate Diploma in Advanced Nursing (Merit), provided independent expert nursing advice to HDC in relation to the care provided to the aggrieved person by [X] in [Month] 20[X].

65. RN Carey has held senior nursing positions in New Zealand, initially as a Clinical Charge Nurse and then as a Nurse Educator.

66. RN Carey advised that the defendant's policies and guidelines which were in place during [Month] 20[X] pertaining to nutrition, hydration, skin integrity, wound management, pain, medical assessment and care planning were clinically appropriate and of a high standard. However, she identified the following concerns:

    a. The completed MNA on 7 [Month] 20[X] was incorrect with unreliable scores inputted, thereby affecting the validity of the nutritional assessment. RN Carey was also critical that a nutritional assessment could identify a resident as "malnourished" (albeit incorrectly) with no interventions to manage this identified risk eventuating.

    b. On 9 [Month] 20[X], the pressure wound started to deteriorate. In terms of the wound observations on 10 [Month] 20[X], slough and necrotic tissue is non-viable and their presence would delay wound healing. Debridement to remove such tissue is an important part of wound bed preparation and management of infection. This was not done.

    c. Over the ensuing fortnight, several RNs recorded the increasing deterioration of both the wound and the aggrieved person's general

condition. However, no action was taken to change the wound care plan, refer the aggrieved person to a wound care specialist nurse or for reassessment by the GP when it appeared infected and not improving. Specialist wound care advice should have been sought on 15 [Month] 20[X]. By this stage, the aggrieved person had had her pressure wound for almost two weeks and it was deteriorating despite regular wound care.

d. The MDR on 16 [Month] 20[X] was a missed opportunity to review both the sacral wound and the administration of PRN zopiclone.

e. The discovery of reduced air mattress pressure on 16 [Month] 20[X] is concerning as the pressure is determined by weight. Reducing the pressure would impair the pressure-relieving quality of the mattress.

f. A GP review should have been sought on 18 [Month] 20[X] due to the aggrieved person being a diabetic, immobile resident who had a deteriorating sacral pressure injury and who was by then withdrawn, upset and with a poor dietary intake.

g. Nursing staff repeatedly recorded the aggrieved person's poor dietary intake from 10 [Month] 20[X] but failed to implement appropriate actions in response.

h. There was a lack of comprehensive assessment of the aggrieved person's vital signs before 1pm on 23 [Month] 20[X]. Nursing staff were noting concerning signs – hallucinations and confusion, looking very unwell, cold and pale limbs with capillary refill of 6 seconds, all indications of sepsis.

i. The aggrieved person's vitals at 1.25pm and 2.45pm on 23 [Month] 20[X] indicated that the aggrieved person was comatose, pyrexial

(had a high body temperature), bradycardic (had a low heart rate), hypotensive (had low blood pressure) and tachypnoeic (had abnormally rapid breathing).

67. RN Carey identified a series of recurring failures by several RNs looking after the aggrieved person in the face of several significant clinical presentations and several opportunities for further assessment. The failures involved core nursing competencies within the RNs' scopes of practice (for example, failing to respond appropriately to the changes being recorded by nursing staff, and standard nursing knowledge on the prevention and management of pressure injuries) and reflect a lack of insight into the recognition and management of significant presentations.

68. RN Carey advised that, overall, there was a lack of appropriate assessment, critical thinking and action in response to the aggrieved person's deteriorating condition and the nursing care significantly departed from accepted professional standards.

69. RN Carey advised HDC that the defendant had ultimate responsibility to ensure all nursing staff were adequately familiar with the policies and procedures that were in place, complied with its policies and provided nursing services of an appropriate standard. The defendant failed to fulfil its obligations in this regard.

DEFENDANT'S RESPONSE TO THE COMPLAINT

70. The defendant accepts that at each point when a change in the sacral pressure wound was identified, decisions regarding changes to the dressing plan should have been considered and acted on. The defendant advises that the RNs had a misguided belief that their role was only to inform the CM or UC, who would arrange any necessary follow-up. The defendant advises that, although all qualified staff were able to arrange a

GP review or referral to allied health, historically this was completed by the UC or CM, hence the lack of follow through by the RNs.

71. The defendant acknowledges there was confusion among the RNs about the process for escalating issues for further clinical management. The defendant acknowledges that the layers of RNs, UC and CM in a small care home may have resulted in the roles and responsibilities of the CM and UC being blurred, which may have contributed to inaction.

72. The defendant acknowledges that it would have been appropriate to consider a referral to a dietician when the pressure area was first identified and that relevant referrals to a dietician or the GP should have been made when the aggrieved person's appetite decreased further and the wound continued to deteriorate despite regular wound dressings.

73. The defendant accepts the scores on the MNA are inaccurate when compared with the progress notes recording the aggrieved person's appetite and eating habits, and the fact that she had put on some weight.

74. The defendant identified that staff focused on the aggrieved person's personal issues as the cause of her decreased appetite and low mood, and that this was a significant contributing factor in staff not recognising and acting on the general decline in her condition.

75. The defendant acknowledges that giving zopiclone to the aggrieved person in the early hours of the morning was not good practice.

76. The defendant acknowledges that the level of care provided to the aggrieved person at [X] in [Month] 20[X] did not meet the expected standard of care required for a younger resident with chronic medical conditions and complex comorbidities. The defendant accepts responsibility for these failures.

77. Following the aggrieved person's death, the defendant instigated an internal review, which it acknowledges identified gaps in communication and planning of care. The defendant advises that it has made a number of practice changes and remedial actions as a result of this incident, including:

a) Improved managerial oversight through daily and weekly meetings, including review of residents with current wounds.
b) Nursing handover changes including a bedside/visual check of all residents assessed as unwell.
c) Education and coaching on wound care, effective clinical communication,[14] role and responsibilities, nutrition and hydration, and the learnings from the internal investigation into [the aggrieved person's] care.

78. Further corrective actions and initiatives include:

a) Review of the senior clinical team at [X]. It was determined that with only 32 residents at [X], there was a blurring of responsibilities between the UC role and the CM role. Following the then current UC transferring to another Bupa facility, her role was disestablished, and coordination responsibility of the hospital unit devolved to the CM.
b) A new CM has been recruited and has fully completed orientation at [X], with additional mentoring over a period of months from an experienced registered nurse relief Care Home Manager.
c) Regular follow-up clinical and care home audits have been conducted at [X] by Bupa's ... Operations Manager and senior members of the Nursing, Quality and Risk team.
d) Review and release of Bupa's Pressure Injury Prevention and Management policy, including clearer guidance on classification, prevention, assessment, and management of injuries. The policy also references a change in practice for reporting serious injuries to HealthCERT, and specifies expected timeframes for healing, and guidance on action and escalation where healing is delayed.
e) Review of Bupa's education plan and policy.
f) Review of the multi-disciplinary review (renamed resident review) policy, including prompts for GPs and nurses to review usage of PRN (as required) medications on the review checklist,

[14] By introduction at [X] of ISBAR, an internationally recognised communication tool providing a framework for clinical conversations between health professionals.

discussion/documentation of discussion of frequency of PRN medication usage, and healing progress of any current wound.

g) Commencement of a Clinical Manager Project, and development of a Clinical Manager Framework and Clinical Manager Orientation Programme.

h) Creation of a Clinical Manager leadership programme for completion by all CMs within two years in five cohort groups.

i) Implementation of an electronic medication management system across all Bupa care homes, with all care homes due to be transitioned by December 2016.

j) Implementation of an electronic incident management system across Bupa care homes, due for pilot in early 2017, and full rollout in all care homes commencing mid-2017.

k) Employment of three senior nurses with capacity to fulfil relief Care Home and/or Clinical Manager roles due to any leave or vacancies.

l) A new role of Clinical Advisor to provide clinical expertise, leadership and education to all staff at Bupa facilities in the ... region, as directed by Bupa's ... Operations Manager.

79. RN Carey advises that the actions and process changes reported by the defendant are appropriate.

BREACH OF THE CODE

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

81. The defendant had a responsibility to operate [X] in a manner that provided its residents with services of an appropriate standard. The New Zealand Health and Disability Sector Standards ("NZHDSS") also require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.[15]

[15] New Zealand Health and Disability Sector (Core) Standards (NZS8134.1.12:2008, Standard 2.2).

82. Nursing staff at [X] individually and as a team failed to act on observations of the aggrieved person's deteriorating sacral pressure wound and her deteriorating overall condition.

83. The inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that did not sufficiently support and assist staff to do what was required of them.

84. The defendant had the ultimate responsibility to ensure that the aggrieved person received care that was of an appropriate standard and complied with the Code. The defendant accepts that it failed in that responsibility and breached Right 4(1) of the Code.

Kerrin Eckersley
Acting Director of proceedings

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

For and on behalf of
Bupa Care Services NZ Limited

Date