Summerset Group Holdings Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC01449)

Contents

Executive summary

1. This report concerns the care provided to a woman by Summerset Group Holdings Limited (Summerset) during her admission to rest-home/hospital-level care. There were several oversights in the woman's wound care relating to a delay in seeking specialist advice, timely and appropriate interventions, inconsistent wound care documentation, and minimal pressure prevention strategies. In addition, the woman's pain was poorly managed, her nutritional intake declined, and there was a lack of oversight from senior staff over the care provided.

2. The report highlights the need for nursing staff to be alert to changes in a resident's condition, and the importance of providers seeking specialist advice in a timely manner, communicating effectively with one another, and completing documentation to support appropriate care planning and interventions.

Findings

3. The Deputy Commissioner considered that the care provided to the woman by Summerset was inadequate, as specialist advice was not sought in a timely manner for her deteriorating wounds, and her analgesia regimen was not well managed. Accordingly, the Deputy Commissioner found Summerset in breach of Right 4(1) of the Code.

Recommendations

4. The Deputy Commissioner recommended that Summerset report back to HDC on its Corrective Action Plan; use this report as a basis for staff training; provide training to its staff on wound care, pressure area prevention, and pain management; review its wound management policy; and provide a formal written apology to the woman's advocate.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her late friend, Mrs A,[1] at Summerset. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mrs A by Summerset Group Holdings Limited between 2 Month1[2] and 28 Month2 2017.*

6. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

[1] Mrs B was appointed by the High Court of New Zealand as the administrator of Mrs A's estate.
[2] Relevant months are referred to as Months 1–3 to protect privacy.

7. The parties directly involved in the investigation were:

Mrs B	Complainant
Summerset Group Holdings Limited	Provider

8. Further information was received from:

Dr C	General practitioner
RN D	Wound nurse practitioner
Medical centre	Provider
RN E	Wound nurse practitioner
RN F	Registered nurse
District health board	
Coroner	

9. Also mentioned in this report:

RN G	Registered nurse

10. Independent expert advice was obtained from Registered Nurse (RN) Jan Grant (Appendix A) and Nurse Practitioner (NP) Jenny Phillips (Appendix B).

Information gathered during investigation

Introduction

Mrs A

11. Mrs A (aged in her eighties) had been a resident in an independent villa at the retirement village since 2013. On 2 Month1, following an admission to a public hospital, Mrs A was admitted to the rest home part of the village.

12. Mrs A's discharge summary from the public hospital noted:

> "Decline in mobility following cellulitis … arterial ulcer[3] on left leg (significant [peripheral vascular disease][4] and mediastinal lymphadenopathy[5] suspicious for neoplastic process."[6]

13. On 5 Month2, Mrs A was assessed as requiring hospital-level care at Summerset.

[3] An ulcer caused by inadequate blood supply to the affected area.
[4] Narrowing of arteries causing restricted blood flow around the body.
[5] Enlarged lymph nodes in the chest area.
[6] Growth of a tumour.

14. This report concerns the care provided to Mrs A from her admission to rest home/hospital-level care at Summerset, to her readmission to the public hospital on 27 Month2 with sepsis from infected pressure ulcers.

15. Mrs A was treated palliatively in hospital, and she died on 29 Month2.

Summerset

16. At the time of these events, Summerset provided rest-home and hospital-level care in dual-purpose beds in the Care Centre, and to rest-home-level care residents in serviced apartments. A medical centre is contracted to Summerset to provide general practitioner and nurse practitioner services to Summerset.

17. The leadership structure at Summerset was that a Clinical Nurse Leader reported to the Care Centre Manager, who reported to the Village Manager. The Village Manager role was non-clinical. The Care Centre Manager role included people leadership, driving the culture of the Care Centre, maintaining effective relationships with residents and families, and managing resources and budgets. The Clinical Nurse Leader role included assisting the Care Centre Manager with leadership in the Care Centre, taking charge of the Care Centre as required, monitoring individual resident care plans, and working as part of the nursing team.

18. At the time of these events, a new Village Manager took over on 19 Month1. However, the new manager told HDC that she did not start in the role officially until 16 Month2, owing to an overseas trip. RN F was the Care Centre Manager, and RN G was the Clinical Nurse Leader.

19. RN F was on leave from 17 Month1 to 4 Month2, and during that time RN G covered both the Care Centre Manager role and the Clinical Nurse Leader role. RN G was on leave from 10 Month2 to 15 Month3, and during that time RN F covered both the Clinical Nurse Leader role and the Care Centre Manager role.

20. RN F commented that she had to juggle significant demands during the time she was covering both roles, and RN G commented that it was busy and he needed to work long hours to do all he needed to while he was covering both roles.

21. RN F said that her normal practice was either to attend handovers from the night shift, or to speak with RN G or the most senior nurse on duty each morning to obtain updates on residents. RN F stated: "[During RN G's absence, there was] a greater reliance on good verbal handover and raising issues directly with me. Staff were reminded of this several times a day."

22. RN F told HDC that leave applications were capped to a specific maximum to ensure that safe rostering could be maintained, and she does not recall any significant concerns being raised by nursing or care staff in relation to acuity or staffing during this period.

Care provided to Mrs A from 2 Month1 to 27 Month2

23. At the time of her admission to Summerset rest home, Mrs A had a long-standing 2cm x 2cm arterial ulcer on the shin of her left lower leg. Previously this had been treated by district nurses. Mrs A also had dry lesions and itchy skin on her lower legs, with some ooze noted. She had peripheral oedema in her lower legs and feet, limited sensation in her feet owing to peripheral neuropathy, and a history of gout and osteoarthritis. From 2 to 17 Month1, Mrs A's left lower leg ulcer was dressed daily, and then the dressings were changed to alternate days.

24. Summerset told HDC that Mrs A's mobility fluctuated, and at times she could walk with her walking frame assisted by one person, and at other times she required assistance from two people and a hoist transfer, as she became very fatigued and short of breath. She required two-person assistance while showering, and had a sensor mat in front of her bed owing to a history of falls. Mrs A used continence products but was independent with toileting. On admission, Mrs A weighed 84.3kg, and she was noted to eat a normal diet.

25. Mrs A's friend, Mrs B, held an Enduring Power of Attorney for Mrs A's care and welfare, but this was not activated. Mrs B was also listed as Mrs A's next of kin, as Mrs A did not have family in New Zealand.

26. Mrs A's medications on admission to Summerset included gabapentin 300mg daily for neuropathic pain, and paracetamol 500mg 2 tablets up to four times daily as needed for pain. A pain assessment undertaken on admission noted that her pain was 2/10, and that analgesia was to be administered "as per the chart".

27. On 2 Month1, Mrs A's Waterlow score[7] was assessed as 29 (very high risk). However, no pressure prevention strategies were recorded, and the Waterlow assessment was not repeated.

28. That day, a grade 2 pressure injury was noted on Mrs A's right heel. This was documented on a care centre events form.[8] A short-term care plan and a wound assessment and treatment plan were commenced on 5 Month1. The wound was described as 40% necrotic,[9] 3cm x 3cm, and 0.2cm deep.

29. The care progress notes from 2 Month1 state that a caregiver "noticed wounds on [Mrs A's] arms & legs, she said she was scratching them, informed RN". There is no evidence of any action being taken at that time in relation to the wounds described.

30. On 3 Month1, a registered nurse documented: "[N]oticed some fluid leaking from the swollen right lower leg applied Gamgee[10] and compression bandage." Summerset told

[7] The Waterlow gives an estimated risk for the development of a pressure sore in a given patient.
[8] Care centre events are defined on the form as any harm, injury, illness, or incident involving a care centre resident arising from care but not related to the natural course of a resident's illness or underlying condition.
[9] Dead cells or tissues.
[10] An absorbent surgical dressing.

HDC that this actually referred to a firmly applied crêpe bandage, and that Summerset staff are not trained in the application of compression bandaging, and would refer to specialist staff to complete this for residents who required it.

31. Mrs A was commenced on a hydration chart on 4 Month1, but this was discontinued on 8 Month1 owing to adequate fluid intake.

32. On 6 Month1, a wound assessment and treatment plan was started for a skin tear on Mrs A's left lower calf. The wound evaluation form describes the wound as 1cm x 1cm with 100% granulation[11] tissue. The form notes that Mrs A's pain during the first dressing was 5/10 and paracetamol was given. This is the only record of paracetamol being given for a dressing change.

33. On 7 Month1, Dr C from the medical centre reviewed Mrs A and noted areas of keratosis[12] on her lower legs, and also several areas of skin that was still intact but vulnerable. Dr C stated: "[T]he known chronic ulcer was not painful and more comfortable at that time." RN G said that he accompanied the GP at this visit and noted that the left lower leg ulcer appeared to be granulating.

34. On 15 Month1, a caregiver documented in the progress notes that Mrs A had "bleeding on her buttocks, [and that the] RN [was] informed". On 18 Month1, a registered nurse documented that there was a urine scald on Mrs A's sacrum. A dressing was applied and a short-term care plan and a wound assessment and treatment plan were commenced, which recommended dressing changes every three days. At that time, the wound was described as 0.5cm x 0.5cm, superficial, and 100% granulation tissue.

35. On 23 Month1, a resident centred care plan was completed. It states:

> "[Mrs A] has not reported any pain experience or discomfort on admission. But due to her having ulcers and [peripheral vascular disease] she is bound to be in pain and there are pain relief in place if required … encourage [Mrs A] to verbalise feelings of any discomfort or pain. Monitor for symptoms of pain … observe for objective cues of pain like facial grimace, irritability and guarding behaviour."

36. RN G asked Dr C to review Mrs A on 28 Month1, as she had been complaining of general itchiness for one week, and on the previous night she had been scratching her lower legs and blood spots were noted on the bed sheets. Dr C said that when she reviewed Mrs A, she was no longer itchy. Dr C noted decreased peripheral oedema, dry skin, and increased turgor[13] of the skin on Mrs A's feet, and prescribed urea cream.[14]

[11] Wound granulation refers to the new tissues and blood vessels that grow in a wound during the healing process.
[12] Non-cancerous skin condition that appears as a waxy brown, black, or tan growth.
[13] Skin elasticity. Skin with poor turgor takes time to return to its normal position. Skin with normal turgor snaps back rapidly to its normal position.
[14] A non-greasy emollient or moisturiser.

37. RN G told HDC that Mrs A's general condition appeared to be declining and her dependency on staff was increasing; she was becoming more incontinent, and although she had a urine scald, there was no other apparent pressure injury. RN G commenced an interRAI assessment for Mrs A on 2 Month2 as he was concerned about the deterioration in her general condition. In RN G's opinion, Mrs A required hospital-level care. The assessment was sent to the District Health Board needs assessor, and Mrs A was approved as a hospital-level resident on 5 Month2.

38. RN G said that during his assessment he identified that Mrs A needed an alternating pressure mattress, but none were available or able to be reassigned from another resident. He said that he informed RN F of this on her return from leave, so that one could be purchased. RN F told HDC that she does not recall any particular information relating to Mrs A's wound care being given during the short verbal handover from RN G after she returned from leave. Summerset told HDC that it does not have evidence that a pressure-relieving mattress was provided for Mrs A. However, it noted that it is not always documented when a pressure-relieving mattress is used. In response to the provisional opinion, Mrs B stated that no pressure-relieving mattress was provided.

39. Until 2 Month2, Mrs A's left lower leg ulcer was described as static or improving, despite the wound being described as purulent[15] on 29 Month1.

40. On 7 Month2, staff commenced a turning chart for Mrs A. There are lengthy gaps between some recorded turns.[16] Summerset acknowledged that Mrs A's turning chart appears incomplete. It commented that sometimes caregivers provide intervention to residents (eg, during repositioning for meals) and do not think to record this on the turning chart. It is Summerset's expectation that the registered nurses on each shift monitor recording on the turning charts.

41. The care progress notes from 7 Month2 state that Mrs A "complained of pain on bottom".

42. On 9 Month2, a photograph was taken of Mrs A's urine scald. This showed that the scald now covered both buttocks. From 9 to 27 Month2, the wound evaluation form states that this wound was improving.

43. On 10 Month2, Nurse Practitioner RN D from the medical centre was asked to review Mrs A. RN D prescribed ural sachets, a soothing cream (Bepanthen), and a barrier cream (zinc and caster oil cream) for the urine scald on Mrs A's perineal and sacral area. RN D noted that Mrs A might require a temporary indwelling catheter if these treatments were not effective. RN D said that Mrs A was not added to the clinic lists again for this problem, so she presumed that the issue had resolved with the prescribed measures. RN D told HDC that no other issues were raised by the staff or Mrs A herself, so she did not undertake any other assessments or view Mrs A's pressure areas.

[15] Containing pus.

[16] For example, on 7 Month2 the last recorded turn was at 9pm, and the next recorded turn is at 8.30am the following day. On 9 Month2 there are no recorded turns from 6am to 3pm.

44. On 10 Month2, a short-term care plan was started for the urine scald treatment. The plan recommended two-hourly repositioning, daily application of the prescribed creams, monitoring of Mrs A's pain, and checking that the dressing was intact.

45. Also on 10 Month2, staff reported a grade 2 pressure injury on Mrs A's left heel, and a short-term care plan was started, as well as a wound assessment and treatment plan. At that time, the wound was described as 2.5cm x 1.5cm (with no depth recorded) and sloughy and yellow in appearance. The wound was not re-dressed until 15 Month2.

46. On 13 Month2, Mrs A's weight was noted to be 83.4kg. From 16 Month2, Mrs A's nutritional intake began to reduce. Summerset told HDC that it does not appear that the need for nutrition support was considered. RN F told HDC: "[R]egrettably, I was not made aware of [Mrs A's] reduced intake which would normally happen when monitoring showed ongoing poor intake." In response to the provisional opinion, Mrs B told HDC that Mrs A's weight loss and lack of nutrition was noticed by all her visitors. Mrs B said that she provided supplement drinks for staff to give to Mrs A with meals, but a supplement drink was provided to Mrs A on only one occasion.

47. Summerset told HDC that nursing staff should have considered catheterisation around 17 Month2, as the urine scald did not appear to be responding to the treatment prescribed by RN D. However, this did not occur.

48. On 19 Month2, a further wound assessment and treatment plan was commenced for Mrs A's left shin and calf wounds. The area was described as having been scratched on 16 Month2. The wounds were described as consisting of 50% necrotic tissue and 50% slough, with purulent yellow exudate.[17]

49. On 20 Month2, Mrs A was added to RN D's clinic list, as the nursing staff wanted antibiotics charted for Mrs A's left lower leg. RN D did not view Mrs A's pressure areas. RN D stated:

> "They [registered nursing staff] declined to take down the [left lower leg] dressing, citing cost, and showed me an undated photo of the area. I had not seen the area before. I noted from her discharge information (letter) that [Mrs A] had long term arterial ulcers of both lower legs. The undated photo showed a superficial infection of a wound on the lower left leg but no surrounding tissue involvement … [Mrs A] had no evidence of systemic infection with no change in her vital signs or behaviour and because of this I prescribed a topical antibacterial cream to be applied daily. This is so the wound could be monitored by the Registered Nurse."

50. RN F stated that not taking down a dressing for cost reasons was incorrect, and she never promoted such a justification during her time at Summerset. RN F said that it was her understanding that Mrs A's wounds had been seen by RN D, and given that Mrs A was

[17] Fluid that leaks out of blood vessels into nearby tissues.

prescribed an antibacterial treatment, RN F took it that Mrs A's wounds did not require other treatments or additional clinical input.

51. The care progress notes for 20 Month2 state that Mrs A "ate and drank a little … was in pain from legs and bottom". The care progress notes for 21 Month2 state that Mrs A did not eat or drink anything and was "in so much pain".

52. On 22 Month2, Mrs A's right heel wound was described as 3cm x 2cm (with no depth listed). Mrs A's left heel wound was described as 100% necrotic and 4cm x 5cm (with no depth listed). Mrs A's pain during the dressing change was recorded as 9/10.

53. Also on 22 Month2, Mrs A's left shin and calf wounds were described as 10cm x 7cm and 5cm x 6cm, 1cm deep, and not improving; a pain score of 5/10 was recorded during six dressing changes for these wounds. There is no evidence of paracetamol being given for these reported complaints of pain on 20, 21, or 22 Month2.

54. Dr C next reviewed Mrs A on 23 Month2. Dr C noted that Mrs A had a necrotic area on her left heel that had increased in size (compared to photographs Dr C was offered), and that the area surrounding the chronic ulcer showed increased signs of inflammation. Dr C diagnosed inter-current cellulitis and initiated oral antibiotics. Dr C contacted RN D that evening and arranged for her to contact the wound care nurse practitioner from the DHB, RN E, to review Mrs A. RN D telephoned and emailed RN E. The email mainly contains information from Summerset nursing staff, and states:

> "[Mrs A's] L) heel and L) lower leg wounds are necrotic despite pressure dressing and pressure care with derma pad in place. The GP has reviewed the wounds and prescribed antibiotics to start today … GP would like you to assess the wound when you are able for instructions of correct dressing product to break up the thick necrotic tissue that we are unable to debride easily … They are chronic wounds she obtained before admission to facility and she has a history of peripheral neuropathy."

55. RN E advised that debridement would not be in Mrs A's best interests owing to her peripheral arterial disease, and recommended keeping a protective dry dressing over the necrotic tissue. RN E said that she would be inclined to check that the blood flow to Mrs A's foot was sufficient to support healing before making a referral to the plastic surgery team, because, if not, then they would not be able to assist. RN E requested a referral so that she could see Mrs A and provide advice during her next visit to Summerset on 26 Month2. RN D then sent a referral to RN E.

56. RN F told HDC that in response to reports of pain from the care staff, she recalls discussing Mrs A's pain levels with a registered nurse on 23 or 24 Month2. RN F said that she asked the nurse to check the analgesia prescribed, and whether it was being given and was effective, and to have it reviewed if it was not effective. She said that she went to see Mrs A to assess how she was, and at that time she appeared to be comfortable. RN F stated that no further pain issues were reported to her over the next few days.

57. On 24 Month2, a hydration chart was recommenced. This showed that from 24–27 Month2, Mrs A drank between 300 and 900ml of fluid each day.

58. On 26 Month2, RN E reviewed Mrs A and noted the following:

a) A left lower leg ulcer that had been present for some time, measuring 10cm x 15cm and with exposed non-viable tendon in the base of the ulcer.

b) Bilateral heel pressure injuries approximately 5cm x 5cm, which were dry and covered by black eschar.

c) Pressure-related damage on the dorsum (tops) of both feet, which she believed to be from crêpe bandages applied too tightly.

59. RN E told HDC that she was not advised by Summerset staff that Mrs A had a sacral pressure injury. RN E said that because she had a busy case load, she did not undertake a full body assessment of Mrs A. RN E recorded that Mrs A was not on a pressure-relieving mattress, so she requested that staff put one on Mrs A's bed. There is no evidence that this occurred.

60. RN E said that Summerset staff indicated to her that Mrs A's general condition had deteriorated over the preceding week and she was eating less. As Mrs A's wounds were dry without signs of surrounding redness, malodour, or exudate, RN E considered that they were not infected at that time. However, she believed that Mrs A's general condition meant that she might not be fit enough to undergo angioplasty,[18] in which case the wounds would continue to worsen. Accordingly, RN E contacted Dr C, and it was agreed that Dr C would follow up with Mrs A and her family to discuss the next steps (i.e., hospital or conservative care). RN E agreed to review Mrs A again in two weeks' time.

61. On 27 Month2, Mrs A's right heel wound was described as 40% necrotic, 60% slough, and not improving. However, no measurements were documented. Her pain during the dressing change was recorded as 0/10.

62. Mrs B visited Mrs A on 27 Month2. She said that Mrs A was in a bad way — dehydrated, delirious, and very hot. Mrs B said that it was clear that Mrs A was in extreme pain, and she urged the nurse on duty to call an ambulance, which occurred. RN F told HDC that she was on call on 27 Month2, and did not receive any calls in relation to Mrs A's condition that day.

63. Mrs A was taken to the Emergency Department at the public hospital by ambulance, and arrived at 7.51pm. She was found to have a fever, a high heart rate, and low blood pressure. The source of infection was thought to be her left heel ulcer, and she was noted to have bilateral 7cm diameter heel ulcers, a nearly circumferential left ankle ulcer, and large sacral pressure areas.

[18] A procedure to widen narrowed arteries.

64. Mrs A was admitted to the General Medicine ward. A general medicine consultant told HDC that Mrs A was reviewed by the vascular and plastic surgery teams, and it was considered that the wounds could not be managed surgically. The general medicine consultant's opinion was that without surgical intervention, ultimately the wounds would cause Mrs A's death through sepsis. Mrs A's condition was considered to be terminal, and, after discussion with Mrs B, antibiotic treatment was withdrawn and Mrs A was kept comfortable. Mrs A died on 29 Month2.

65. DHB staff were concerned about the extent of Mrs A's pressure areas, and, accordingly, the level of care that had been provided by Summerset. It was therefore arranged for medical photographs of Mrs A's wounds to be taken, and her death was referred to the Coroner, who accepted jurisdiction.

Further information

Policy

66. Summerset had in place a Wound Management Policy (reviewed December 2015). This specified that the "Nurse Manager/Clinical team leader" was responsible for clinical leadership and oversight of all wounds. The policy states that wounds that do not heal must be brought to the attention of the resident's GP, and that residents with chronic or delayed healing of wounds are to be referred to the wound specialist at the nearest DHB.

Wound care

67. Summerset's head of clinical services told HDC:

> "[T]he wound care assessments completed for [Mrs A] contain gaps and inconsistencies. It is clear from the wound care photos that wound and skin breakdown occurred rapidly in the last few days of [Mrs A's] care at Summerset. The assessment of the hospital staff on admission in [Month2] indicates to me that the RN team at the time did not appear to have the required level of wound care assessment skills to ensure effective wound care for [Mrs A]. While it is subjective that this would have changed the outcome for [Mrs A] it is reasonable to assume that increased skill and use of other specialist resources to meet [Mrs A's] needs could have resulted in improved comfort for [Mrs A] … There were multiple RN's involved in the assessments of [Mrs A's] wounds and there is a risk that each wound being assessed and treated in isolation did not assist to identify [Mrs A's] needs."

Pain management

68. Pain assessments during Mrs A's wound dressing changes were frequently recorded as 0/10. After 7 Month2, there were documented occasions where caregivers observed Mrs A to be in pain. Summerset acknowledged that there does not appear to have been sufficient recognition of the issues documented by the caregivers. RN F told HDC: "[R]egrettably, [Mrs A's] pain experience was reported inconsistently and pain scores varied considerably."

69. The medication administration record shows that Mrs A was administered gabapentin daily, but she was administered paracetamol on only two occasions — on 6 Month1 for leg pain, and on 13 Month2 for hip pain — despite this having been prescribed up to four times a day as needed.

Changes made at Summerset

70. RN F resigned from Summerset and stopped working there following these events in 2017. RN G moved into the Care Centre Manager role in 2017.

71. An internal investigation and corrective action plan was completed in September 2017. Summerset reported to HDC that the following actions were implemented as a result of the corrective action plan:

- The Clinical Nurse Leader role has changed to Clinical Manager. The new job description focuses on clinical oversight and increased family contact.
- Training sessions were delivered by the hospice.
- A review of pressure mattresses was undertaken. There is now the ability to rent mattresses if needed.
- A clinical whiteboard has been implemented to improve communication with care staff for monitoring requirements and changes in resident care plans in a timely manner.
- The handover process has improved.
- Monitoring charts (for turning, restraints, etc) are now placed in residents' rooms instead of in their files.
- Wound care education was provided by a nurse practitioner and Smith & Nephew.
- Registered nurse documentation is now included in the progress notes. Previously, nursing and caregiver notes were recorded in separate bodies of notes.
- Continence management training was provided.
- Nutrition and hydration "tool box" discussions occurred.
- Pain management training was provided.
- Pressure area training was provided.

72. Since these events, Summerset has moved to an electronic resident record system (VCare). Summerset advised that this is providing electronic support around wound care monitoring, as it raises alerts when dressings are due for assessment.

73. Summerset told HDC that following this case, Summerset's wound care and pain policies were updated to reflect the need to assess non-verbal signs of pain.

74. RN G told HDC that the following processes for wound care are now in place at Summerset:

- All wound dressings are documented in VCare.
- Night staff print out a separate sheet for the wound dressings that need to be assessed that day.
- The Clinical Nurse Leader regularly checks the wounds to assess their progress.
- Any grade 3 pressure injuries are notified to the Ministry of Health, and at the same time a referral is sent to specialist wound nurses at the DHB.
- Wound photographs are taken and uploaded into VCare.
- The Clinical Nurse Leader follows up on wound dressings, especially chronic wounds, on a daily basis.
- Any wound that has not healed within three weeks is elevated as a chronic wound, and advice from the GP and wound nurse is sought.
- Education and training on how to update and document in the wound assessment and management plan is provided regularly.
- Nurses regularly update the Clinical Nurse Leader on wound product stock levels.

Ministry of Health audits

75. Two Ministry of Health audits have taken place since these events — a provisional audit in 2017 and a surveillance audit in 2019. Both audits focused on wound care management in particular, and there were no adverse findings in this regard. Summerset has a 36-month certification period, with its current certificate ending in 2020.

Responses to provisional opinion

76. Mrs B and Summerset were given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into the report.

77. Mrs B told HDC that on discharge from the DHB, Mrs A had only one long-term ulcer, which was showing good signs of healing through the nursing care that had been provided. Mrs B said that although Mrs A was uncertain on her feet, she was able to walk with a walker. Mrs B stated: "A programme of rehabilitation would have reaped benefits for [Mrs A], and extended her quality of life."

78. Summerset stated that it accepts that there were deficiencies in the care that its staff provided to Mrs A, and that it has ultimate responsibility for the care that was provided. Summerset accepted the provisional findings, and provided a written apology for Mrs B.

Opinion: Summerset Group Holdings Limited — breach

Introduction

79. Summerset had a duty to provide Mrs A services with reasonable care and skill. This included responsibility for the actions of its staff at Summerset, and an organisational duty to facilitate continuity of care. Summerset also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

> "**Service Management Standard 2.2**: 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."

80. Mrs A's medical history indicated that she was likely to experience a progressive decline in her general function, and she was particularly at risk for developing pressure wounds. As such, in my view, the various Summerset nursing staff involved in her care should have been alert to changes in her condition, and should have reacted more rapidly to her wound care, pain management, and nutritional needs. My expert advisor, RN Jan Grant, commented:

> "[Mrs A] suffered from multiple medical problems and certainly her health was compromised. The documentation presented showed an adequate assessment of her potential problems, but in my opinion once these were identified the overall care lacked robustness and consistency ... I am of the opinion that staff should have initiated expert advice far sooner, they also should have used equipment which would have supported pressure management, namely a pressure mattress. I also believe pain management was inconsistent, from my experience it is difficult to see that any person with the wounds that [Mrs A] developed did not have chronic and acute pain."

81. There were deficiencies in the care provided to Mrs A by multiple staff at Summerset, which, in my view, were systemic issues for which Summerset bears responsibility. These are outlined below.

Wound care

82. Mrs A's wounds included the following:

- An arterial ulcer on her left lower leg, which was present on her admission to Summerset;
- A pressure injury on her right heel, which was noted on the day of her admission;
- A skin tear on her left lower calf, which was first noted on 6 Month1;
- A urine scald, which was first identified as bleeding on her buttocks on 15 Month1; and
- A pressure injury on her left heel, which was first noted on 10 Month2.

83. When Mrs A was admitted to Summerset she was assessed as a very high risk for developing pressure sores, but no pressure prevention strategies were put in place at that time. There is no evidence that a pressure-relieving mattress was used throughout Mrs A's admission, and a turning chart was not implemented until 7 Month2. There are large gaps between some recorded turns on the turning chart.

84. On 10 Month2, nurse practitioner input was sought for Mrs A's urine scald. RN D said that at that assessment no further issues (eg, pressure areas) were raised regarding Mrs A. On 20 Month2, RN D was consulted regarding Mrs A's left lower leg. RN D stated that she was shown a photograph of the wound, and the wound dressing was not taken down because of cost, and she prescribed an antibacterial cream, as Mrs A did not have evidence of systemic infection. Dr C saw Mrs A on 23 Month2 and initiated oral antibiotics for Mrs A's left heel ulcer. Dr C also initiated a referral to the DHB, and RN E attended on 26 Month2.

85. RN E noted that Mrs A had a 10cm x 15cm ulcer on her left lower leg with exposed non-viable tendon in the base of the ulcer, bilateral heel pressure injuries 5cm x 5cm covered by black eschar, and pressure-related damage to the dorsum of both feet from crêpe bandaging. RN E said that she was not told by Summerset staff that Mrs A had a sacral pressure injury. On Mrs A's admission to the public hospital, medical photographs of her wounds were taken, owing to concerns about the extent of the pressure areas.

86. Summerset stated:

> "[T]he wound care assessments completed for [Mrs A] contain gaps and inconsistencies … The assessment of the hospital staff on admission in [Month2] indicates to me that the RN team at the time did not appear to have the required level of wound care assessment skills to ensure effective wound care for [Mrs A] … There were multiple RN's involved in the assessments of [Mrs A's] wounds and there is a risk that each wound being assessed and treated in isolation did not assist to identify [Mrs A's] needs."

87. My expert advisor, RN Grant, commented that Mrs A's initial assessments in relation to wound care were within acceptable standards. However, she noted that there were some inconsistencies between the time of wounds being identified in the progress notes, and care plans and wound care charts being commenced. For example, Mrs A's scratching on her legs was noted on admission, but a wound care chart was not commenced until 6 Month1. RN Grant also advised that compression bandaging should not be used in the presence of arterial leg ulcers, as it may compromise circulation further. However, I note Summerset's explanation that the reference in the notes to compression bandaging actually referred to firmly applied crêpe bandaging.

88. RN Grant stated:

> "I am of the opinion that a pressure mattress should have been provided on admission and expert advice from medical staff and a wound care nurse specialist should have

> been requested much earlier than it was. An appropriate time to request specialist help would have been when [Mrs A's] skin was beginning to break down.
>
> I also believe that some of the documentation relating to the wound assessment was lacking accuracy; photographs obviously demonstrate a wound picture that was not accurately recorded. Taking all of the issues into account I believe my peers would see this as a moderate/severe departure from acceptable standards."

89. My expert nurse practitioner advisor, Jenny Phillips, advised that nurse practitioners are advanced practitioners who have clinics and set appointment times to see their patients, and, as such, they rely on accurate referral data from the rest-home nurses. She commented that the advice given by the nurse practitioners in this case was appropriate. However, NP Phillips stated: "I fail to understand why the Rest Home staff had not sought help much sooner for these wounds, or even alerted the GP to their presence."

90. I accept the advice of RN Grant and NP Phillips. I am very concerned about the following omissions in Mrs A's wound care:

- Not all of Mrs A's wounds were brought to the attention of RN D and Dr C, the left lower leg dressing was not taken down for RN D, and specialist wound care advice was not sought in a more timely manner for Mrs A despite her history of peripheral vascular disease and very high risk of developing pressure areas.
- Despite being identified as at very high risk of developing pressure areas, there is no evidence that Mrs A was put on a pressure-relieving mattress during her admission, and a turning chart was not commenced until 7 Month2, and this was not completed adequately.
- Although compression bandaging may not have been used, on 26 Month2, RN E identified pressure-related damage to the dorsum of both of Mrs A's feet from crêpe bandaging. This is particularly concerning in light of Mrs A's already compromised circulation.
- The wound care documentation contained gaps and inconsistencies, there were delays between wounds being identified and appropriate documentation being commenced, and photographs of Mrs A's wounds demonstrate that the condition of the wounds was not recorded accurately.

Pain management

91. Mrs A's medications on admission to Summerset included gabapentin 300mg daily for neuropathic pain, and paracetamol 500mg, two tablets up to four times daily as needed for pain. Mrs A's resident centred care plan stated:

> "[Mrs A] has not reported any pain experience or discomfort on admission. But due to her having ulcers and [peripheral vascular disease] she is bound to be in pain and there are pain relief in place if required … encourage [Mrs A] to verbalise feelings of

> any discomfort or pain. Monitor for symptoms of pain … observe for objective cues of pain like facial grimace, irritability and guarding behaviour."

92. The medication administration record shows that Mrs A was administered gabapentin daily, but she was administered paracetamol on only two occasions — on 6 Month1 for leg pain, and on 13 Month2 for hip pain. Pain assessments during Mrs A's wound dressing changes were frequently recorded as 0/10. After 7 Month2, there were documented occasions where caregivers observed Mrs A to be in pain.

93. RN Grant advised:

> "I am of the opinion that [Mrs A's] pain management was inconsistent, irregular and not proactively managed. The resident centred care plan clearly documents what would be expected care and how pain was to be managed. There is little evidence that this plan was followed. It is my opinion that with the wounds that [Mrs A] had on admission, and the wounds that developed rapidly deteriorated after admission, it would be highly unlikely that there would be little or no pain. The GP had charted 4hrly Paracetamol PRN. This medication was only given twice during her stay and I could not find any reason for this to be withheld. As her cognitive state also declined [Mrs A] may have displayed different clues to indicate she was in pain, and yet nothing in the documentation states or evaluates that this possibility was considered. I suggest that a more effective analgesia regime on admission would have been to use Paracetamol on a regular basis and to use additional analgesia prior to dressing the painful wounds if necessary. Regular review of pain management is needed as a patient's condition deteriorates as happened with [Mrs A]. There is no indication that the doctor was requested to review the pain management.
>
> [Mrs A's] [next of kin] states that she visited [Mrs A] on [27 Month2] and that she found her in extreme pain. Again, the wound chart lists [Mrs A's] pain as 0/10. I believe my peers would view the pain management as a severe departure of current professional standards."

94. I accept RN Grant's advice. I am particularly concerned that Mrs A's resident centred care plan appears not to have been taken into account by multiple Summerset nursing staff who were involved in Mrs A's dressing changes. Mrs A had several wounds that required regular dressing changes, and despite pain being noted in the wound care documentation and progress notes on multiple occasions, she was administered paracetamol only twice during her admission. I also query the accuracy of the reports of Mrs A experiencing "0/10" pain during dressing changes. Given the extent of Mrs A's wounds, I consider it highly unlikely that she was not experiencing any pain. In my opinion, Summerset staff should have done more to assess whether Mrs A was giving objective cues of pain.

Nutrition/fluid management

95. From 16 Month2, Mrs A's nutritional intake began to reduce, and Summerset acknowledged that it does not appear that the need for nutrition support was considered.

RN Grant advised that adequate assessment and monitoring of Mrs A's nutrition and fluid management was undertaken, but commented:

> "As [Mrs A's] condition deteriorated with worsening of her various pressure areas, and her appetite simultaneously deteriorated, it would have been appropriate for staff to consider the use of protein rich nutritional supplements. This would have required the involvement of medical staff."

96. I agree that nutritional supplements should have been considered for Mrs A in light of her declining nutritional intake, and am concerned that this did not occur.

Clinical management

97. At the time of Mrs A's admission to Summerset, the Village Manager changed, and there were periods where RN G and RN F were covering both the Care Centre Manager and Clinical Nurse Leader roles while the other took leave. RN F commented that there were significant demands to juggle during the time she was covering both roles, and she referred to placing greater reliance on good verbal handover and staff raising issues directly with her. RN G commented that it was busy and that he needed to work long hours to do all he needed to while he was covering both roles.

98. RN Grant advised:

> "I believe the statements show that there were inconsistencies with leadership at senior nursing staff level. Clearly over the [public holiday], a number of the nursing staff were away. This has contributed to a lack of both clinical leadership and monitoring of cares/supervision for caregiving staff. However, in saying this, in no way does it excuse the daily care and lack of consistency in relation to wound care and pain management."

99. I accept RN Grant's advice. I am concerned at the paucity of senior nursing staff during Mrs A's admission, and consider that the lack of leadership and oversight of residents may have contributed to some of the deficiencies in Mrs A's care.

Conclusion

100. In my view, Summerset had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). Overall, there were serious issues with the care Mrs A received at Summerset. In particular:

a) There were several oversights in Mrs A's wound care relating to a delay in seeking specialist advice, timely and appropriate interventions, inconsistent wound care documentation, and minimal pressure prevention strategies.

b) Mrs A's analgesia regimen was not well managed, and she was administered paracetamol on only two occasions during her admission, despite multiple reports of

pain, and multiple wounds that were likely to have been painful during dressing changes.

c) As Mrs A's nutritional intake declined, the need for nutritional supplementation was not considered.

d) There was a lack of senior nursing presence during Mrs A's admission, leading to less direct oversight of residents' care.

101. In light of these issues, I consider that the care provided to Mrs A by Summerset was inadequate, and resulted in specialist advice not being sought in a timely manner for her deteriorating wounds, and her analgesia regimen not being well managed. Accordingly, I find that Summerset did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[19]

Communication with next of kin

102. RN Grant commented:

> "It is noted that [Mrs B] was not aware of the severity of the wounds [Mrs A] had. There is no evidence that staff initiated a meeting with the [next of kin] to provide information about [Mrs A's] progress and an outline of the care being provided as her condition deteriorated. Accurate and timely communication with designated [next of kin] is an expectation that both patients and their families have."

103. I note this advice, and consider that the communication with Mrs B about Mrs A's condition could have been better. As Mrs A did not have family in the country and her condition was deteriorating, it was important for Mrs B, as Mrs A's next of kin and enduring power of attorney, to be kept informed.

Recommendations

104. In the provisional opinion, I recommended that Summerset provide a written apology to Mrs B and the family of Mrs A for the issues identified in this report. Summerset has now provided an apology, and this has been forwarded to Mrs B.

105. I recommend that Summerset:

a) Schedule further regular and ongoing education sessions for all Summerset nursing staff on the following topics:

i. Chronic wound management

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

ii. Pressure area prevention and management including the "SSKIN" approach to manage and prevent pressure damage.

iii. Pain assessment, particularly in relation to assessment of non-verbal signs of pain.

b) Use an anonymised version of this report as a case study, to encourage reflection and discussion during the above education sessions. The anonymised case study should be distributed to all Summerset rest-home/hospital-level care facilities so that there is an opportunity for wider learnings.

c) Provide an update to HDC on the effectiveness of the actions that have been implemented as a result of the corrective action plan.

d) Provide evidence to HDC that the above recommendations have been implemented, within three months of the date of this report.

e) Review its Wound Management Policy to ensure that it reflects best practice principles,[20] and report back to HDC on the outcome of that review within 12 months of the date of this report; and continue to review its Wound Management Policy and consider whether an annual review is required.

Follow-up actions

106. Summerset Group Holdings Limited will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

107. A copy of this report will be sent to the Coroner.

108. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Summerset Group Holdings Limited, will be sent to the Health of Older People Team at the Ministry of Health, and it will be asked to consider reviewing aged residential care access to specialist wound-care expertise and the consistency of practice across all DHBs.

109. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Summerset Group Holdings Limited, will be sent to HealthCERT, the DHB, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[20] Consider the "Guiding principles for pressure injury prevention and management in New Zealand Review", May 2017.

Addendum

110. Following negotiations with the provider, the Director of Proceedings decided to issue proceedings in the Human Rights Review Tribunal by consent.

Appendix A: Independent advice to the Commissioner

The following advice was obtained from RN Jan Grant:

"I have been asked to provide an opinion on the care provided to [Mrs A] by Summerset.

I have no personal or professional conflict of interest in the case. My advice is based on a review of the documentation provided.

I have read and agreed to the Commissioner's guidelines.

I am a Registered Nurse with over 30 years of experience in Aged and Community Care. In that time, I have had a variety of roles. I have been Manager and Director of Nursing of an aged care facility and in community care for 17 years. I have represented the NZNO and the Aged Care Sector on several national working parties. I have been involved in setting standards for Practice for Gerontology Standards. I have been a clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My immediate past role was as Clinical Advisor/Rehabilitation Coordinator in the community. I am a designated assessor for ACC. I have post graduate qualifications in nursing and a Masters degree in management, with nursing ethics and research as a focus.

Background

[Mrs A] initially lived in an independent villa at Summerset Retirement Village. In [Month1], [Mrs A] was admitted to the rest home as she required support for her activities of daily living. She had spent some time in [the public hospital] and was discharged to a rest home bed at [Summerset]. Her medical discharge letter states that her medical diagnoses from admission to [the public hospital] were: Decline in mobility following cellulitis; Arterial ulcer on left leg secondary to significant peripheral vascular disease and mediastinal lymphadenopathy suspicious for neoplastic process. [Mrs A] had multiple medical problems listed as:

- IHD, PCI to LAD
- Peripheral neuropathy
- Hypertension
- Hyperlipidaemia
- Osteoarthritis
- Essential tremor
- GORD
- Right THJR 2010
- Iron deficiency anemia

- Previous mechanical falls
- Previous OPR2 admission following gout flare
- NKDA
- Previous smoker

The medical discharge letter states that while [Mrs A] was an inpatient she had poor healing of her left leg ulcer, suspected to be an arterial ulcer. She showed mediastinal lymphadenopathy which was thought to be due to a neoplastic process but was not keen for further investigation. [Mrs A] was discharged on 10 medications.

[Mrs A] had been assessed with an Interai [in 2016]. This assessment showed that [Mrs A] needed some support with decision making and her friend Mrs B was listed as her EPOA. There was no family in New Zealand. At assessment [Mrs A] was able to understand and spoke clearly. She stated that her mental function declined when she was tired. She wore two hearing aids. [Mrs A's] functional status was listed as reduced mobility, limited standing, limited walking tolerance and impaired balance. She was reported to have some loss of sensation in her hands. She was unable to perform general housework, meals and other household duties.

Personal cares were needed and at the time of assessment one person was required to assist with showering. Assistance was needed for all mobility and personal dressing. Mobility was limited and fluctuated at times. Both bladder and at times faecal incontinence occurred. Pads were required. [Mrs A] reported a poor appetite. Skin conditions listed were a long-standing arterial ulcer on the lower left leg. It was described as 2cm x 2cm in dimension and due to arterial stenosis. Dry red lesions were observed and her skin was itchy. Some ooze was noted from her lower legs. [Mrs A] had limited sensation in her feet due to peripheral neuropathy and peripheral oedema in her lower legs and feet. The summary was that it was not safe for [Mrs A] to return to her home and she was assessed as requiring rest home care.

Her admission to Summerset was on 2 [Month1].

Questions

1. The adequacy of [Mrs A's] wound care regime

[Mrs A] had several wounds on admission:

Buttocks
The first documentation of the wound on the buttock was in the care progress notes. On 15 [Month1] a caregiver noted at 1945hrs: 'bleeding on her buttocks, RN informed'. On 18 [Month1] at 1130hrs the RN documented: 'Urine scald noted on sacrum wound dressing done. WCP (wound care plan) + STCP (short term care plan) commenced. Incident form done NOK informed'. On 26 [Month1] a caregiver noted '[Mrs A's] skin on bottom broken and bleeding CNL informed'. On 29 [Month1] the caregiver notes 'dressing on bottom off RN informed'. At 2200hrs RN documented

'[Mrs A] was … asleep when writer went to do her wound dressing. To apply wound dressing mane'.

On 3 [Month2] the care progress notes state 'had bleeding in buttocks informed RN; bed sodden'. On 7 [Month2] 'Complained of pain on bottom', 'she doesn't have dressing on her pressure area, informed nurse'.

The clinical handover report of the 18 [Month1] states 'Urine scald on sacrum WCP + STCP done. NOK notified.'

A short term care plan was commenced on 18 [Month1]. The goal was to promote healing of the urine scald on the sacrum. Included in the interventions was to check the integrity of the surrounding skin daily and report to the RNs if the skin condition deteriorates. Dressing was to be changed as per the wound care plan. Staff were to monitor for pain and report to RN immediately.

The wound care assessment and treatment plan was commenced on the 18 [Month1]. At this time the wound was described as 100% granulation tissue. The surrounding skin was described as fragile. The wound was described as 0.5cm in width, 0.5cm in length and superficial in depth. The dressing was done on 18 [Month1], 21 [Month1], 22 [Month1], 28 [Month1], 29 [Month1], 31 [Month1], 4 [Month2], 5 [Month2], 9 [Month2], 12 [Month2], 18 [Month2], 21 [Month2], 24 [Month2] and 27 [Month2].

Four evaluations appear on the evaluation page of the short term care plan.

The turn charts were not commenced until 7 [Month2] some 23 days after this was first reported by a caregiver.

A short term care plan was commenced on 10 [Month2] with appropriate interventions that included a 2 hourly repositioning chart, application of cream as prescribed daily to buttocks, checking for intact dressing and monitoring for pain.

On 9 [Month2] a photo was taken and this clearly demonstrates that there had been an increase in size to cover both buttocks, from the top of the sacrum to the bottom. There is evidence of full thickness loss of skin in places and it appears that the wound had deteriorated from when the plan was first documented.

On 9 [Month2] the wound documentation is listed as 'improving'. Staff have documented that the wound was improving right up until 27 [Month2], when she was admitted to [the public hospital]. Photographs taken at [the public hospital] on 28 [Month2] show full thickness skin loss and black necrotic tissue at the sacral crease. The wound, in my opinion, had certainly increased in size, depth and severity.

Right Heel

This wound was first documented on a short term care plan on the 5 [Month1]. Staff described a grade 2 pressure area. The wound evaluation form describes the wound

on 6 [Month1] as being 40% necrotic, 3cm in width and length and 0.2cm in depth. By 22 [Month2] the wound is described as 3cm in width and 2cm in length while depth is not listed. By 27 [Month2] the description of the wound is that it had not improved, 40% necrotic and 60% slough. No measurements were listed. The pictures taken at [the public hospital] show the wound to be far greater in size and severity than as described by the wound chart.

Left Heel

The left heel wound assessment and treatment plan commenced on 10 [Month2]. At this time, it was described as grade 2. It was sloughy and yellow in appearance. There was moderate wound exudate, the surrounding skin was fragile, and the size was listed as 2.5cm in width, 1.5cm in length and no depth was listed. There was no pain reported. This wound was not redressed again until 15 [Month2], 5 days from the first dressing. By 22 [Month2] the wound was 100% necrotic. It had increased in size and was now 4cm in width, 5cm in length but no depth was listed. By 26 [Month2] the wound dimensions were 5cm x 5cm. A short term care plan was documented on 26 [Month2], one day prior to admission to [the public hospital].

Left Lower Leg

This wound was present at the time [Mrs A] was admitted to [Summerset]. It was listed as a chronic wound/ulcer. This wound was dressed daily from 2 [Month1] until 17 [Month1] when it was changed to every second day. The wound assessment and treatment plan documentation shows that staff assessed the wound as static in nature up until 25 [Month2]. This conflicts with the documentation of the wound exudate which is described as purulent from 29 [Month1]. The size of this wound also changed from being described as 1cm x 1cm on 31 [Month1] to 2cm x 3.5cm on 4 [Month2].

Left Shin and Left Calf

The date of assessment was listed as 19 [Month2]. The area was described as being scratched on 16 [Month2]. At the time it was listed, the wound evaluation chart shows that there was 50% necrotic tissue and 50% slough. It was purulent with yellow exudate present. The size is listed on 22 [Month2] as 10cm x 7cm. The wound is described as not improving and the pain level is estimated as 5/10 at each dressing change which took place daily except for one day.

Pressure Area Cares

A turning chart was commenced on 7 [Month2]. As previously stated, this chart was commenced some 23 days after the first reporting of concern by caregivers. This chart is used to document the time a patient is turned and what position the patient is in. At the commencement of the turning chart, the times that [Mrs A] was turned are listed as 0900hrs, 1200hrs, 1230hrs, 1400hrs, 1730hrs and 2100hrs.

The chart is completed daily with glaring omissions. There are several hours on certain days when the chart was either not completed or [Mrs A] was not turned. Examples are: on 7 [Month2] the last recorded turn was at 2100hrs and the next recorded turn

at 0830hrs the following day. On 9 [Month2] there are no recorded turns from 0600hrs until 1500hrs; on 13 [Month2] from 0600hrs to 1500hrs; on 14 [Month2] from 2000hrs; 1000hrs on 15 [Month2]. Throughout the documentation there are large gaps in the turn chart.

Care progress notes identify wounds on the arms and legs on the day of admission (2 [Month1]). The entry states 'noticed wounds on her arms, 2 legs, she said she was scratching them, informed RN'.

Summary of Wound Care
The evaluation of wound care is in two parts — firstly, the assessment and preventive measures taken and secondly the wound care itself.

The assessment data collected on admission meets adequate standards. As identified, there was a Waterlow pressure area assessment undertaken on the 2 [Month1], the day of admission. I believe the rating of a very high risk was correct. The Initial Care and Support Plan, also completed on the day of admission by a registered nurse, was also in my opinion an accurate collection of data and needs for [Mrs A]. In relation to skin care it identified that [Mrs A] had dry lesions on both legs, an arterial ulcer on the lower left leg and had peripheral oedema of both legs. Special creams were required. From this assessment one would expect to see a proactive approach to skin care and prevention of further pressure wounds. I could find no evidence of a pressure air mattress being provided for [Mrs A]. With a complex medical history, wound history and limited mobility, I would have expected to see a pressure mattress provided from the time of admission.

Wound care — As identified, a number of wound charts and assessments were undertaken. Each wound had an individual chart, wound assessment and treatment plan. I question some of the start times for wound care plans as care staff identified wounds and concerns in the progress notes, but it is not until sometime later that a care plan and wound chart was commenced. An example of this is: on the day of admission at 2100hrs, the care staff have documented that they had noticed wounds from the patient scratching on her arms and legs. They go on to state that they had informed the RN, yet there is no short term care plan or wound chart for these events until 6 [Month1]. There was a wound chart and care plan for the chronic wound commenced on admission.

I also question the use of compression bandaging; medical notes indicate that the registered nurse applied this on 3 [Month1] 'Bilateral legs appear as swollen commenced STCP for that. Noticed some fluid leaking from swollen right lower legs applied Gamgee and compression bandage'. The medical notes in the discharge information from [the public hospital] do not indicate that compression bandaging was being used. Certainly, compression bandaging is not used in the presence of arterial leg ulcers and may even compromise the circulation further. In my opinion

compression bandaging should only be commenced if advised by either a doctor or an advanced nurse such as a nurse practitioner.

There are also times in the wound care programme when no dressings were applied. Staff have noted in the care progress notes: RN entry 29 [Month1] '[Mrs A] was asleep when writer went to do dressing, to apply wound dressing in mane'. The dressing wound assessment indicates that the wound was not redressed until the 31 [Month1].

I am of the opinion that my peers would view the documentation of initial assessment as being within acceptable standards.

I am of the opinion that a pressure mattress should have been provided on admission and expert advice from medical staff and a wound care nurse specialist should have been requested much earlier than it was. An appropriate time to request specialist help would have been when [Mrs A's] skin was beginning to break down.

I also believe that some of the documentation relating to the wound assessment was lacking accuracy; photographs obviously demonstrate a wound picture that was not accurately recorded. Taking all of the issues into account I believe my peers would see this as a moderate/severe departure from acceptable standards.

2. The Adequacy of [Mrs A's] Analgesia Regime

A pain assessment tool was documented on 2 [Month1]. It states that [Mrs A] has pain at 2/10 at time of assessment. The plan was to encourage [Mrs A] to express her pain and to administer analgesia as needed as per chart. The next review date listed on this document was PRN. There is no evidence that another pain assessment was undertaken.

[Mrs A] was admitted with a number of medications. Her analgesia included Gabapentin 300mg twice a day for neuropathic pain and Paracetamol 500mg x 2 four times a day for pain. Her medical discharge letter indicated Paracetamol 1g QID PRN. On [Mrs A's] Summerset medication chart Paracetamol 500mg tabs, 2 tabs QID are charted in the PRN medication section. [Mrs A's] HC Assessment version 9.3 completed [in 2016] states that on the day of assessment client denied any pain. However, incidents reported in the client notes state 'prescribed regular paracetamol'.

There is evidence in the drug administration chart that Gabapentin was administered 'as per drug charting' but I could only find evidence that she was administered Paracetamol 500mg twice on 6 [Month1] for leg pain and again on 13 [Month2] for hip pain.

The clinical picture that [Mrs A] presented with and her rapidly deteriorating wounds, indicate that she would, in all likelihood, be experiencing widespread chronic pain. The care progress notes on 7 [Month2] state: 'complained of pain on bottom', on 20 [Month2] 'ate and drank little, pad changed, was in pain from legs and bottom', on 21

[Month2] 'did not eat and drink anything, in so much pain' and on 22 [Month2] 'very sore on her bottom and legs'.

A Resident Centred Care Plan was commenced on admission and completed on 23 [Month1]. It includes a heading of 'Pain Experience'. At the time of the assessment it is noted that '[Mrs A] does not report any pain or discomfort on admission'. The interventions of the care plan state: 'encourage [Mrs A] to verbalize feelings of any discomfort or pain. Monitor for symptoms of pain and RN to assess pain. Observe for objective cues of pain. RN to administer analgesia as charted PRN. Refer to GP for further pain management when pain gets worse'. There were not evaluations of pain in the care plan.

Each wound has a dressing chart. Assessment of the wound was undertaken at every dressing change. Included in this form was a Pain Assessment score. Pain was assessed at each dressing change. Pain is recorded from 1–10, one being no pain and ten being severe pain. Throughout the dressing changes the pain levels varied from 0–9. The days when pain was listed as higher than 2 were shown as: 6/10 on 19 [Month1], 6/10 on 12 [Month2], 5/10 on 6 [Month1], 4/10 on 9 [Month1], 6/10 on 7 [Month2], 6/10 on 13 [Month2], 7/10 on 16 [Month2], 9/10 on 22 [Month2] and 5/10 on 25 [Month2]. At all other times the pain level is shown as 0/10.

The wound assessment and treatment plan for the L shin and the L calf which was commenced on 19 [Month2] identify [Mrs A's] pain level as 5/10 at each dressing change, a total of 6 changes until 27 [Month2]. No Paracetamol was administered at any dressing change.

The pain assessment on the wound chart does not coincide with comments made in the care progress notes. An example of this is: on 21 [Month2] the notes state 'did not drink anything in so much pain' the wound notes show a pain score of 0/10.

As previously stated, Paracetamol was only given on 6 [Month1] at 1922hrs and 13 [Month2] at 0917hrs. The drug charts show that no Paracetamol was given on the occasions staff listed high pain levels following dressings.

Summary
I am of the opinion that [Mrs A's] pain management was inconsistent, irregular and not proactively managed. The resident centred care plan clearly documents what would be expected care and how pain was to be managed. There is little evidence that this plan was followed. It is my opinion that with the wounds that [Mrs A] had on admission, and the wounds that developed rapidly deteriorated after admission, it would be highly unlikely that there would be little or no pain. The GP had charted 4hrly Paracetamol PRN. This medication was only given twice during her stay and I could not find any reason for this to be withheld. As her cognitive state also declined [Mrs A] may have displayed different clues to indicate she was in pain, and yet nothing in the documentation states or evaluates that this possibility was considered. I suggest

that a more effective analgesia regime on admission would have been to use Paracetamol on a regular basis and to use additional analgesia prior to dressing the painful wounds if necessary. Regular review of pain management is needed as a patient's condition deteriorates as happened with [Mrs A]. There is no indication that the doctor was requested to review the pain management.

[Mrs A's] NOK states that she visited [Mrs A] on 27 [Month2] and that she found her in extreme pain. Again, the wound chart lists [Mrs A's] pain as 0/10.

I believe my peers would view the pain management as a severe departure of current professional standards.

3. The Adequacy of [Mrs A's] Nutrition/Fluid Management

On admission nutrition was assessed in several ways. The initial care and support plan identify Diet/Fluids. It lists [Mrs A] as having a poor appetite, eating a normal diet, free fluids and having breakfast in bed. A Dietary Requirement form was also completed on admission. The information on this form indicated that [Mrs A] ate independently and had normal meals. It listed what she would prefer for breakfast and had no special preferences. Fluid balance charts were completed for 2 [Month1], for a half day on 6 [Month1], a full day on 7 [Month1] and a full day on 8 [Month1]. On the 8 [Month1] a note is made in the medical notes stating that she had been on a fluid balance chart and as she had a good intake the FBC was discontinued.

In the Resident Centred Care Plan dated 23 [Month1] under Nutritional intake eating and drinking, her weight on admission is listed as 84.3kg. Appropriate goals and interventions are documented.

The care plan progress notes indicate that [Mrs A] ate and drank well until 16 [Month2] when the notes indicate that she 'ate and drank a little'. On 18 [Month2] the notes indicate 'eating and drinking minimally'. This continued until 21 [Month2] when she did not eat or drink anything. On 24 [Month2] 'poor appetite' was recorded. A fluid balance chart was commenced on 24 [Month2], showing that a small amount of fluids were consumed — 350ml on 24 [Month2] and 870ml on 25 [Month2]. On 27 [Month2] 650ml were taken. Food charts were commenced on 25 [Month2] and 27 [Month2].

I note that the letter of complaint by [Mrs A's] NOK indicated that [Mrs A] did not always eat her meals and that meal trays were removed with [Mrs A] not having eaten anything. I can find no proof of this in the documentation presented.

From the documentation presented, I am of the opinion that adequate assessment and monitoring was undertaken.

I would, however, make this additional comment: As [Mrs A's] condition deteriorated with worsening of her various pressure areas, and her appetite simultaneously deteriorated, it would have been appropriate for staff to consider the use of protein

rich nutritional supplements. This would have required the involvement of medical staff. There is no evidence that this took place.

4. The timeliness of involvement of [Dr C], [RN D] and [RN E] and the adequacy of information provided to them regarding [Mrs A's] wounds

[Mrs A's] medical care was provided by [Dr C]. The medical notes show that [Dr C] visited 5 [Month1] and documented an assessment although [Mrs A] was not seen at that time but was seen on 7 [Month1]. On 23 [Month2], [Dr C] requested referrals to be sent to a wound care nurse and the plastic surgical department. [Mrs A] was also seen by [a doctor] on 29 [Month1].

Nurse Practitioner [RN D] visited on 10 [Month2]. In her statement she states that she was asked to see [Mrs A] due to urine scald to her perineal area. She prescribed treatment. She also noted that an indwelling catheter be used if the measures she had charted were not effective. I am unsure if she physically examined [Mrs A], her notes do not state or confirm this. Problems with skin breakdown of the sacral area had already been noted for approximately 3 weeks prior to the nurse practitioner's visit. She recommended application to the affected area of a barrier cream and zinc and castor oil as an extra barrier for the skin. Following her visit, she ordered a soothing cream (Bepanthen Cream) to provide a soothing component. The wound chart shows that the sacrum was dressed every 3 days. The wound care chart states that the wound was dressed on 9 [Month2], 12 [Month2], 18 [Month2], 21 [Month2], 24 [Month2] and 27 [Month2]. There is nothing in the wound care evaluation form to state that the wound had cream applied to it daily. Photograph evidence is available to show what the sacrum looked like on the 9 [Month2] i.e. the day prior to [RN D's] consultation. [RN D] did not personally document in the medical notes. It appears her instructions were documented by another RN.

She visited again the following week and staff did not identify that [Mrs A] needed to be seen. She was next seen on 20 [Month2] when staff refused to take down the wound dressing, citing cost. They did show [RN D] a photograph of the sacral wounds, for which she prescribed local antibacterial cream. [RN D] was then asked by the Doctor to send referral to wound care NP which she did.

[RN E] wrote an email explaining a referral was needed and the chance of being seen by the plastic surgical team was unlikely.

I agree with [RN D] that as a visiting health professional she is reliant on staff to identify and assess patients. It is also my opinion that if staff have asked for a review then it is reasonable to expect the NP to visually assess wounds and plan accordingly to her assessment. I would also expect the NP to document her findings in the medical notes. In addition, interventions and frequency of reviews should be documented. It is concerning that staff refused to take down the wound and did not identify other wounds which required review.

I believe it needs to be clarified that [RN D] directly examined any of [Mrs A's] wounds. Advice from another Nurse Practitioner re treatment options should have been sought.

I believe the advice from medical staff with respect to the various wounds was based on a discussion with nursing staff and I question if nursing staff placed enough emphasis on the severity of the wounds and the rapidity of their deterioration.

I believe that a Nurse Practitioner should review and provide an option on wound care with instruction and appropriate documentation.

5. The standard of advice provided by [RN D] and [RN E]

As stated previously, clarification needs to be made as to whether [RN D] viewed any of the wounds, or instead gave advice following discussion with the facility staff. [RN D], it seems, was asked to review [Mrs A] for urine scalds to the perineum and her treatment recommendations reflect this. However, at this stage of [Mrs A's] admission there was a picture of multiple rapidly deteriorating wounds. There is a photograph of the sacral and buttock pressure area dated 9 [Month2], the day before [RN D] saw [Mrs A] for the first time. It appears that [RN D] did not have access to the photograph which shows the extent of the skin breakdown.

[RN E] visited on the 26 [Month2] and her notes are thorough and comprehensive. They outline assessment and options for interventions. She also asked for what appears to be a pressure mattress.

Advice should be sought from a NP as to the advice provided. Certainly, [RN E's] notes are comprehensive and appropriate.

[RN D's] advice, in my opinion, depends on if she viewed the wounds. I would expect her to view all wounds and document appropriately. It is my opinion that when she visited on 10 [Month2] [Mrs A] had a number of wounds and photo evidence shows these were severe in nature. Pictures taken on the 15 [Month2] and the 22 [Month2] show deterioration in both severity of pressure areas and their size. I would expect well documented review and appropriate interventions.

6. The adequacy of care provided by Summerset in respect of its staffing levels

From the information provided in the rosters and the subsequent response from Summerset I cannot give a definitive answer to the staff levels.

7. The adequacy of the policies in place at Summerset

One policy was presented with the documentation I viewed. This was the Wound Management Policy. This document was 4 pages long. The policy outlined the Purpose, Responsibilities, Wound Assessment, Documentation, Management and the care of chronic wounds. There is an associated document list which is current and appropriate to use.

Other policies presented appear to be education slides such as Infection Control and Promoting Good Nutrition and Hydration. There are also slides in relation to pressure areas.

Information in these documents is clearly presented and in line with current practice.

8. Any other matters in this case that you consider warrant comment

Communication with [Mrs A's] NOK was documented in the clinical records, when she expressed concern about levels of pain. However, it is noted that she was not aware of the severity of the wounds [Mrs A] had. There is no evidence that staff initiated a meeting with the NOK to provide information about [Mrs A's] progress and an outline of the care being provided as her condition deteriorated. Accurate and timely communication with designated NOK is an expectation that both patients and their families have.

Summary

[Mrs A] suffered from multiple medical problems and certainly her health was compromised. The documentation presented showed an adequate assessment of her potential problems, but in my opinion once these were identified the overall care lacked robustness and consistency. There are question marks as to whether the NP viewed all the wounds. I am of the opinion that staff should have initiated expert advice far sooner, they also should have used equipment which would have supported pressure management, namely a pressure mattress. I also believe pain management was inconsistent, from my experience it is difficult to see that any person with the wounds that [Mrs A] developed did not have chronic and acute pain."

The following further advice was received from RN Grant:

"I have been asked to provide further expert advice following a review of additional documents. These documents included a response from Summerset, updated appendices A–H, and a statement from former Nurse Manager [RN F], dated 6th September, 2019.

Questions:

1. Whether the further documentation reviewed causes you to add or to amend the conclusions drawn in your initial advice.

Having read all the supporting documentation and statements from various parties, I have not changed my original advice. I believe that the internal investigation/review identified the same issues that I had identified in my original advice. I believe the statements show that there were inconsistencies with leadership at senior nursing staff level. Clearly over the [public holiday], a number of the nursing staff were away. This has contributed to a lack of both clinical leadership and monitoring of cares/supervision for caregiving staff. However, in saying this, in no way does it excuse the daily care and lack of consistency in relation to wound care and pain management.

I believe that [Mrs A] had multiple medical problems and her needs were complex.

2. The adequacy of changes implemented at [Summerset] since these events.

The changes that have been made include expansion of the Clinical Manager's role so that there is now more focus on clinical oversight and increased family contact. A new Management Team has been appointed and support has been provided at a corporate level.

A better communication system is in place. There is now a white board to identify cares and any changes made. Monitoring charts are placed in residents' rooms. Education in the following areas has been introduced: Wound care, pressure area care, continence management, and pain management.

Clinical notes, documented by Registered Nurses, are now included in the current progress notes in order to improve communication between registered nursing staff and care staff.

The improvements that have been made will enhance staff education and staff communication between care staff and registered nurses.

A Certification Audit was undertaken [in 2017] and it is reported that no findings were made in terms of these areas of improvement. This demonstrates that Summerset has undertaken adequate improvement measures.

3. Any other matters in this case that you consider warrant comment.

No other comments are required. I would make no changes to my original advice."

Appendix B: Independent advice to the Commissioner

The following advice was obtained from NP Jenny Phillips:

> "This report has been compiled using the competencies for the nurse practitioner scope of practice (Nursing Council of NZ, (NCNZ) 2017). It is essential that people understand the role of the Nurse Practitioner (NP) as working 'autonomously and in collaborative teams with other health professionals to promote health, prevent disease, and improve access and population health outcomes for a specific patient group or community.' (NCNZ p 1.)
>
> Nurse Practitioners are advanced practitioners, who maintain their nursing focus, but the organisation of their work is more medical — that is they have clinics and set appointment times to see their (usually) very large group of patients. As such, they rely on accurate referral data, and each of the NPs states how they do this — for [RN D], there is an appointment diary for her clinics which is completed by the nurses at the Rest Home and for [RN E], a referral needs to be sent to the DHB.
>
> The HDC has requested specific information relating to the assessment and advice provided by [RN D] on 10 and 20th [Month2] and [RN E] on 26 [Month2].
>
> **[RN D] —10 [Month2]:**
> *What is the standard of care/accepted practice?*
>
> [RN D] provided correct assessment and recommended 3 days of conservative treatment, with the recommendation for catheterisation if this did not resolve the problem. As [Mrs A] was not referred to her again, she assumed that the situation has resolved with the conservative treatment.
>
> *How would it be viewed by your peers?*
>
> I consider this would be favourably viewed by any of her peers or anyone who understands the NP role.
>
> *Recommendations for improvement that may help to prevent a similar occurrence in future.*
>
> If the issue was not resolved with the conservative treatment, the RNs needed to refer [Mrs A] back to the clinic for further review.
>
> **[RN D] — 23 [Month2]:**
> *What is the standard of care/accepted practice*
>
> Within her scope the standard of care was acceptable. However, as was seen when [RN E] visited, the standard of care by a specialist wound NP was different. On the issue of oral antibiotics, they would be unlikely to have a significant effect on the wounds given the level of arterial impairment.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

Antibacterial creams are not recommended best practice for any wounds, but I would not expect an NP (or nurse) who is not specialising in wounds to know this. Using them will not cause harm, but an antimicrobial wound dressing is the preferred option. It would have been useful if [RN D] had recommended to the staff that they contact [RN E] — particularly as she was already booked to attend the Rest Home.

How would it be viewed by your peers?

Any non-specialist in wound NP would probably agree with the action taken, any specialist NP or Clinical Nurse Specialist in wounds would recommend an antimicrobial wound dressing and repeat review by themselves, and probable liaison with GP.

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

I fail to understand why the Rest Home staff had not sought help much sooner for these wounds, or even alerted the GP to their presence.

[RN E] — 26 [Month2].

What is the standard of care/accepted practice?

[RN E's] assessment and standard of care was excellent including the observation that [Mrs A] was probably not fit enough to undergo her planned angioplasty. She discussed her concerns with the GP and arranged to review [Mrs A] again in 2 weeks. She also asked staff to order a pressure relieving mattress.

How would it be viewed by your peers?

The advice provided was at an advanced level of wound practice nursing and with any other NP in the speciality would be viewed as the correct course of action.

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

1. She was on a pressure mattress in hospital — was this not conveyed to the Rest Home staff so that they could arrange the same care?

2. What was the patient's Pressure injury risk assessment on transfer to the Rest home or did they not do one?

3. If a risk assessment had been done, this would have provided a basis for a nursing care plan based on the highest risk factors — which would also have included her issue with incontinence.

4. Why was the NP or GP not notified sooner of the deterioration in the wounds?

5. If there had been earlier notification, it is likely that her angioplasty may have been done more urgently preventing all the suffering for this patient.

Reference:
Nursing Council of New Zealand (2017) Competencies for the nurse practitioner scope of practice."