Auckland District Health Board

A Report by the
Health and Disability Commissioner

(Case 14HDC00766)

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Executive summary

1. In 2013, Mrs A gave birth to her first child. The delivery was forceps assisted and Mrs A suffered a third degree tear, which resulted in urinary and faecal incontinence. Consequently, Mrs A was unable to leave the house easily, and she had limited family support in New Zealand.

2. Mrs A later developed a breast abscess and, on 15 Month2[1], underwent surgery to drain the abscess. On 16 Month2 she was discharged and referred to the District Nursing Service (DNS) for ongoing wound care. That day, the DNS received the referral and triaged Mrs A as a "low acuity rating", indicating that she required simple wound care management with no perceived complications. The triage form contains no reference to Mrs A's other health issues or her social and cultural factors.

3. On 17, 18, 19 and 20 Month2 the district nurses used Aquacel rope to pack Mrs A's wound. When packing a wound with Aquacel rope, the end of the rope should remain outside the wound. However, when the district nurses visited, the end of the rope was not always visible, and it was assumed that Mrs A had removed the rope when she had not done so.

4. After 17 Month2, although there are comments in the clinical notes about the healing of Mrs A's wound, there is no objective record of the dimensions of the wound. The district nurses made regular changes to the products being used to treat Mrs A's wound, but the reasons for each change of product are not recorded. At times the district nurses relied on Mrs A contacting her general practitioner (GP) for review rather than making the contact for her.

5. On 4 Month5 a district nurse noted that there was an increased amount of green exudate and that the wound was hypergranulated. The nurse advised Mrs A to see her GP, Dr N, to obtain a referral to the surgical team. On 7 Month5 Dr N referred Mrs A to a general surgeon, Dr M.

6. On 24 Month5 Dr M performed an excision of Mrs A's wound. Following the procedure Mrs A was informed that the reason her breast wound had not been healing was the presence of a 5cm foreign body, which was later identified as a piece of Aquacel rope dressing.

Findings

7. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures. It was the responsibility of ADHB to have in place adequate systems and oversight of staff to ensure that Mrs A received appropriate care.

8. The ADHB DNS screening tool categorised patients according to complexity, but lacked the requirement for specific information that would indicate potential

[1] Relevant months are referred to as Months 1-5 to protect privacy.

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problems; the triage assessment lacked consideration of social or cultural factors that could impact on healing.

9. The Aquacel rope was not used appropriately and the wound was not investigated adequately, and Mrs A was not asked whether she had removed the dressings herself. In addition, the ADHB wound assessment form was not designed to capture objective parameters that would indicate wound progress over time, and district nurses were not recording objective assessments of Mrs A's wound consistently. Accordingly, ADHB failed to ensure that services were provided to Mrs A with reasonable care and skill, and breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

10. By at times relying on Mrs A to contact her GP, rather than the district nurse contacting the GP directly; by making regular changes to the products used without documenting the reason; and for having no peer review and no recorded follow-up of the efficacy of the treatment provided, the district nurses failed to work together effectively. Accordingly, ADHB failed to ensure cooperation among providers to ensure quality and continuity of services to Mrs A, and breached Right 4(5)[3] of the Code.

11. Following this event ADHB undertook a review of policy, standard operating procedures and process and implemented changes. The Commissioner recommended that ADHB provide a report confirming the implementation of changes, including evidence of the communication of these changes to staff; and carry out an independent peer review of the quality of its District Nursing Service wound assessment and evaluation. ADHB was also asked to provide an update of progress regarding the possible introduction of electronic record-keeping within the District Nursing Service, and to provide an apology to the woman.

Complaint and investigation

12. The Commissioner received a complaint from Mrs A about the services provided to her by Auckland District Health Board. The following issue was identified for investigation:

- *Whether Auckland District Health Board provided an appropriate standard of care to Mrs A between 16 Month2 and 24 Month5.*

13. An investigation was commenced on 15 January 2015. The parties directly involved in the investigation were:

[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 4(5) states: "Every consumer has the right to cooperation among providers to ensure quality and continuity of services."

HDC

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Mrs A	Consumer
Mr A	Consumer's husband
Auckland District Health Board	Provider
DN B	District nurse/provider
DN C	District nurse/provider
DN D	District nurse/provider
DN E	District nurse/provider
DN F	District nurse/provider
DN G	District nurse/provider
DN H	District nurse/provider
DN I	District nurse/provider
DN J	District nurse/provider
DN K	District nurse/provider
DN L	Charge nurse manager/provider
Dr M	General surgeon/provider
Dr N	General practitioner/provider

Also mentioned in this report:

DN O	District nurse/provider
DN P	District nurse/provider

14. Independent expert advice was obtained from a registered nurse, Ms Julie Betts (**Appendix A**).

Information gathered during investigation

Background

15. Mrs A, aged 33 years, gave birth to her first child. The baby was delivered by forceps and Mrs A suffered a third degree tear, which resulted in both urinary and faecal incontinence. Owing to her injury, Mrs A was unable to drive or leave the house easily. Mrs A's only family in New Zealand was her husband, Mr A, apart from when her mother visited from overseas for a period after the birth.

16. In Month1, Mrs A developed swelling and pain in her right breast. She saw her general practitioner (GP), Dr N,[4] who prescribed antibiotics for a suspected infection. Initially Mrs A's symptoms improved, but on 7 Month2 she re-presented to Dr N with pain, redness and a lump in her right breast. By that stage Mrs A was no longer breastfeeding owing to the pain in her breast. Dr N referred her to the public hospital (the hospital) for an ultrasound scan.

17. A scan performed on 10 Month2 showed an abscess in Mrs A's right breast. She was referred for surgery to drain the abscess.

[4] Dr N is vocationally registered in general practice.

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Surgery — abscess drained

18. Mrs A's abscess was drained on 15 Month2. The surgery was uncomplicated, and Mrs A's wound was left open to heal by "secondary intention".[5] A wound swab taken to check for infection was negative and further antibiotics were not required. Mrs A was prescribed tramadol[6] and Panadol for pain.

19. On 16 Month2 Mrs A was discharged from hospital. Her discharge summary states that she was referred to the District Nursing Service (DNS) for ongoing wound care, and was to be seen at the hospital for follow-up in three weeks' time. It is also noted on her discharge summary that she had in place a Penrose drain[7] that required daily dressing.

Referral to District Nursing Service

20. The DNS received Mrs A's referral on 16 Month2. District Nurse (DN) D triaged Mrs A with the lowest possible score in all areas (indicating no perceived issues) except under "[s]everity of medical problems e.g co morbidities", for which Mrs A scored one point (scored from zero to two), indicating that Mrs A's health issues were "[m]anaged" with "[s]upport from specialist services …". Mrs A's triage form contains no further reference to her other health issues or social and cultural factors, including that she had suffered a third degree tear during labour and was unable to drive or leave the house easily, or that she did not have any family in New Zealand apart from her husband.

21. DN D assessed Mrs A as having a "low acuity rating", indicating simple wound care requirements with no perceived complications.

22. DN D was the area coordinator,[8] and Mrs A's primary district nurse was DN C.[9]

DNS home visits 17 Month2–20 Month2 — Aquacel rope used

23. Between 17 and 20 Month2, district nurses visited Mrs A every day. On these four visits the nurses packed and redressed Mrs A's wound with Aquacel rope, and documented their assessment of Mrs A's wound in her clinical notes or on the ADHB wound care assessment form. The wound care assessment form contains tick boxes for, among other things, the wound type, appearance of the wound, exudate,[10] appearance of the surrounding skin, and nutritional status.

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[5] The wound is left open to heal without surgical intervention — usually indicated in infected or severely contaminated wounds.

[6] Pain relief used for moderate to severe pain.

[7] A flexible rubber tube placed in the wound to drain fluid.

[8] The area coordinator is available to the primary district nurse for advice and direction on an individual basis.

[9] The primary district nurse is involved in the overall care of the patient in conjunction with the patient's GP. The primary district nurse can consult with the patient's GP or the area coordinator if advice or direction is required.

[10] Fluid coming out of a wound.

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Aquacel rope

24. Aquacel rope is a type of dressing that forms a soft, hydrophilic, gas-permeable barrier when applied to a wound. The product is designed to absorb and retain tissue exudate, and takes on a gel-like appearance as part of that process. When packing a wound with Aquacel rope, about 1cm at the end of the rope should be left resting on the skin.

First occasion Aquacel rope used

25. On 17 Month2 DN B visited Mrs A in her home for an initial assessment because DN C was on leave. DN B confirmed Mrs A's low acuity rating.

26. DN B completed the wound care assessment form, noting that Mrs A had a ten-week-old baby, and that the plan was for the wound to heal within four weeks. The document states that the plan was for daily treatment, which involved cleansing, wound packing with Aquacel rope, and dressing with gauze.

27. According to DN B, Mrs A reported her pain level as 9/10 or 10/10,[11] so DN B advised Mrs A to take her prescribed analgesia (tramadol and Panadol) regularly, and to take analgesia one hour prior to having her dressings changed.

28. DN B recorded in Mrs A's clinical notes that she measured Mrs A's wound with a probe[12] and found it to be approximately 3cm deep. DN B told HDC that she irrigated the wound with saline and recorded that she packed and dressed Mrs A's wound with Aquacel rope, gauze and Hyperfix.[13] DN B said she "packed Aquacel rope approximately 3cm lightly into the cavity, covered with a dry dressing". She told HDC that she "educated" Mrs A on keeping the wound clean and dry, and the importance of removing the packing. DN B stated: "I discussed this as she was going to be showering before each daily dressing change."

29. However, Mrs A told HDC that for approximately the first four weeks of visits from the DNS she did not shower, preferring to sponge bath. Mrs A further stated that she never removed her wound dressing herself.

Second occasion Aquacel rope used

30. On 18 Month2 DN J visited Mrs A and recorded in the clinical notes that her wound had "very slight slough on borders" and that it was cleansed and redressed "as per WCP".[14]

Third occasion Aquacel rope used

31. On 19 Month2 DN J visited Mrs A and assessed her. DN J recorded in the clinical notes that there was "[nil sign] of infection", and that the wound was cleansed, packed and redressed using Aquacel rope, gauze and Hyperfix.

[11] 0/10 being no pain and 10/10 being extreme pain.
[12] A device used for measuring the depth of the wound.
[13] An adhesive, non-woven fabric used in wound dressing.
[14] "Wound care plan".

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Fourth occasion Aquacel rope used

32. On 20 Month2 DN C visited Mrs A for the first time and assessed her. DN C said that she removed Mrs A's Penrose drain and applied a waterproof dressing over the wound so that Mrs A could shower. DN C recorded in the clinical notes that she redressed the wound with Aquacel rope and "… AG[15] just so [patient] can have shower [tomorrow]. Will review & see if needs changing as low exudate on dressing."

33. DN C told HDC that Mrs A's wound was "painful to touch and difficult to pack", and that Mrs A was taking pain relief prior to the district nurse visits. However, the pain and difficulty packing are not documented.

34. DN C noted in the District Nursing Care Plan that Mrs A was unable to drive, and so could not attend the clinic. DN C further noted: "Is waiting further surgery 3rd degree tear — result of giving birth — incontinent …"

DNS home visit 21 Month2

35. On 21 Month2 DN C visited Mrs A and assessed her. DN C recorded in the clinical notes that Mrs A's wound was "more painful today, moderate exudate …". DN C recorded that she irrigated Mrs A's wound and repacked it with Aquacel AG and Hyperfix. She noted: "Review [tomorrow] & if signs of infection, swab. [Mrs A] reluctant to take more [oral antibiotics]." DN C told HDC: "I observed the old dressing which I removed." However, that is not documented.

DNS home visits 22–31 Month2 — ribbon gauze used

36. Between 22 Month2 and 31 Month2 Mrs A was seen by a number of district nurses, and various changes were made to the management of her wound.

37. On 22 Month2 DN D visited Mrs A and noted: "Packing removed, irrigated till clear return. [Nil] inflammation. Still painful to touch." Mrs A had ceased taking tramadol as it was making her dizzy, so DN D advised her to contact her GP for alternative analgesia. DN D noted that she repacked Mrs A's wound with ribbon gauze.[16] DN D told HDC that at this visit:

> "[T]he wound was very tender to touch making it hard to check the depth. I carefully removed the aquacel packing and irrigated the cavity till the return fluid was clear. I could see no evidence of debris and inspected the wound carefully. I decided to use half ribbon gauze soaked in saline and solosite gel.[17] This is much easier to pack and remove."

38. On 23 Month2 DN D visited Mrs A and noted: "[P]acking removed." DN D irrigated Mrs A's wound and repacked it with ribbon gauze. She noted that Mrs A was "feeling much better today".

[15] Reference to Aquacel AG, which is a silver-coated wound dressing product used for moderate to high exudate wounds that are infected or at risk of infection.

[16] Ribbon gauze is a packing gauze that consists of folded absorbent cotton.

[17] Solosite gel is used to create a moist wound environment.

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39. On 24 Month2 DN C noted that Mrs A was taking Panadol only. DN C recorded: "Packing removed. Syringed cavity, repacked with ribbon gauze, gauze and Hyperfix. Pt still not willing to clean herself in shower. Revisit [tomorrow]."

40. On 25 Month2 DN C visited Mrs A and noted that she irrigated Mrs A's wound and repacked and dressed it with ribbon gauze, gauze and Hyperfix. DN C told HDC that Mrs A's wound appeared to be improving. DN C noted in Mrs A's clinical records: "May be able to leave for alternate days after [tomorrow]. Suggested clinic for pt but has no transport to clinic. Revisit tmrw."

41. On 26 Month2 DN C visited Mrs A and noted that her wound was "slightly green, irrigated until clean". DN C noted that she "trialled" repacking Mrs A's wound with Aquacel gauze "buttered" with Flamazine,[18] gauze and Hyperfix. There is no documentation of the rationale for this approach.

42. ADHB stated that the district nurses used a 50g tube of Flamazine cream 1%,[19] and that Mrs A had been prescribed Flamazine and it was kept at her home. However, in contrast, Mrs A told HDC that she was not prescribed Flamazine, and she recalls the district nurses bringing it with them to her house. There is no record that Dr N prescribed Flamazine.

43. DN C told HDC that as the wound swab taken on 15 Month2 had returned as "clear", and as Mrs A's wound was improving, the district nurse visits were changed to alternate days.

44. On 28 Month2 DN E visited Mrs A at home. DN E noted that she "did not have flamazine on [her] so [she] cleansed and redressed" Mrs A's wound before applying Solosite[20] and repacking and dressing the wound with ribbon gauze, gauze and Hyperfix. DN E noted: "See again tomorrow and take flamazine. Exudate today. Pt still refusing to take dressings off and shower. See [tomorrow]."

45. On 29 Month2 DN E visited Mrs A and irrigated her wound, noting a "slight green tinge so used flamazine (left @ home)". DN E packed and dressed the wound with ribbon gauze, gauze and Hyperfix. She noted: "Nil concern."

46. On 31 Month2 DN E visited Mrs A, irrigated her wound and applied Flamazine, before repacking and dressing the wound with ribbon gauze, gauze and Hyperfix.

47. DN E told HDC that she did not probe the wound on any of the days on which she assessed Mrs A "due to increased pain".

Use of Pimafucort

48. On 2 Month3 DN F saw Mrs A for an appointment at the District Nursing Clinic. DN F assessed Mrs A and recorded that, while the wound had begun to close over, there

[18] A topical cream indicated for the prevention of infection in wounds.
[19] Flamazine becomes a prescription-only medication when prescribed in quantities over 50g.
[20] A wound dressing that can provide moisture to rehydrate non-viable tissue. It absorbs exudate while retaining its structure in the wound.

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was an appearance of "slight hypergranulation",[21] and the wound was taking longer to heal than expected. DN F noted that she "trialled Pimafucort[22] Cuticerin[23]" and that she had redressed Mrs A's wound with gauze and Hyperfix and given her "remove wipes" so that she could remove the dressing prior to having a shower. There is no documented rationale for the use of Pimafucort and Cuticerin, and this treatment is not referred to on the Wound Care Assessment form.

49. DN F scheduled Mrs A's following appointment for 4 Month3 to be a home visit, as Mrs A found it difficult to come in to the clinic.

50. On 3 Month3 Mrs A contacted Dr N for a repeat prescription of Panadol 500mg Caplets.

51. On 4 Month3 DN C visited Mrs A and recorded that her wound was ¼cm deep and no longer able to be packed. DN C noted that she cleaned the wound and redressed it with Aquacel buttered with Flamazine, gauze and Hyperfix. She noted on the Wound Care Assessment form that Flamazine/Aquacel plus gauze was to be used on alternate days, and that the wound was being cleaned by "showering".

52. On 6 Month3 DN B visited Mrs A and redressed her wound, noting simply that the wound had "improved+++". DN B told HDC that the wound was "shallow and unable to be packed". However, there is no record of any measurements of Mrs A's wound at that time.

53. DN B noted that there were no signs of infection, and that Mrs A did not complain of pain at this visit. DN B told HDC that the wound was dressed "according to the care plan with flamazine … aquacel dressing (not ribbon) and gauze". However, that is not documented.

54. On 8 Month3 DN G visited Mrs A and noted: "Breast wound healing." DN G noted that Mrs A would "self-care" over the next two days.

55. On 11 Month3 DN C visited Mrs A at her home and noted that her wound was healing, but that there was "moderate exudate & hypergranulating".[24] DN C noted: "[H]ave trialled acticoat flex[25] and Hyperfix." There is no record of the rationale for the change. DN C told HDC that as Mrs A's wound no longer had a cavity, the dressing sat on top of her wound.

56. On 13 Month3 Mrs A was seen by a consultant general surgeon at the outpatient clinic at the hospital and had her wound redressed. The general surgeon reported to Dr N that the wound appeared to be settling.

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[21] The appearance of light red or dark pink flesh that can be smooth, bumpy or granular and forms Beyond near the opening of the wound.
[22] A corticosteroid cream that also contains a broad-spectrum antibiotic and fungicide.
[23] An all-purpose, low-adherent surgical dressing made of smooth acetate gauze.
[24] An excess of new connective tissue beyond the amount required to replace the tissue deficit incurred as a result of skin injury or wounding.
[25] An antimicrobial, silver-coated barrier dressing.

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57. On 14 Month3 the district nurses recorded in Mrs A's clinical notes that there was "some slough and hypergranulation" present, but that no antibiotics had been given to Mrs A at the outpatient clinic. The wound was again redressed with Acticoat Flex and Hyperfix.

58. On 18 Month3 DN H visited Mrs A and noted that her wound had moderate exudate and appeared to be hypergranulating. DN H redressed Mrs A's wound with Hyperfix and gauze and noted: "? may need pimafucort for hypergranulation."

59. On 21 Month3 DN O visited Mrs A and assessed her wound, noting hypergranulation and redness. DN O recorded that Mrs A was in "increased pain". DN O redressed Mrs A's wound and advised her to see her GP because of concerns of a recurring infection.

Consultation with Dr N

60. On the same day, Mrs A saw Dr N regarding the healing of her wound. Dr N noted:

> "Has been having regular dressing. Lately noted swelling and redness around scar region and discharge of pus. Request for management. Stable, alert, conscious. Nil distress."

61. Dr N took a swab from Mrs A's wound to check for infection. He prescribed Curam Duo[26] tablets and Pimafucort ointment.

62. On 25 Month3 DN P assessed Mrs A's wound and recorded that Mrs A was reporting reduced redness and pain. DN P noted that the hypergranulation was "almost flattened" but that there was still a moderate amount of exudate.

63. On 26 Month3 a member of staff at Dr N's surgery called Mrs A regarding the laboratory report from her wound swab, which showed a "moderate growth of Methicillin resistant S. aureus (MRSA)[27] …" It is noted:

> "[S]poken to pt regarding recent laboratory report. pt states she's been seen by district nurse and was advised nil complication noted for healing process. Pt to see district nurse by Friday and if any concern arises, see Dr. for consultation …"

64. No further prescription was provided on this occasion. The DNS did not visit again until 4 Month4.

65. On 4 Month4 DN P reviewed Mrs A and noted that the hypergranulation had settled and that she had changed the dressing back to Acticoat Flex and Hyperfix. There is no record that the district nurse was advised of the MRSA result at that visit, but DN P noted that there was no acute wound infection.

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[26] Curam Duo contains amoxicillin and potassium clavulanate and is used to treat a wide range of bacterial infections.

[27] Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium that is resistant to many antibiotics.

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66. On 7 Month4 a student nurse visited Mrs A and noted that her wound was again hypergranulating. The student nurse cleansed the wound and redressed it with Pimafucort, Cuticerin, gauze and Hyperfix. She recorded: “Pt will self care between visits.”

67. On 10 Month4 DN C noted that Mrs A’s wound had almost healed but it still had moderate exudate. DN C cleansed and redressed the wound with Pimafucort, Cuticerin, gauze and Micropore.[28] She noted: “Advised Pt if still ongoing on 13th will swab … advised [Mrs A that she] may need to get checked for MRSA. Review on 13th or may need a scan.” DN C told HDC that she advised Mrs A to discuss the possibility of an MRSA infection with her GP.

68. On 13 Month4 DN C visited Mrs A and noted increased exudate. DN C swabbed Mrs A’s wound and redressed it with Aquacel AG, gauze and Micropore. DN C noted that she would contact Mrs A’s GP and discuss the swab result.

DN C contacts Dr N

69. On 17 Month4 DN C contacted Dr N and noted in Mrs A’s clinical notes that the swab result showed MRSA. DN C documented that she redressed Mrs A’s wound with Aquacel AG, gauze and Hyperfix, and that Mrs A would see her GP to obtain oral antibiotics and would be seen by the DNS again on 20 Month4.

Second consultation with Dr N

70. On 17 Month4 Mrs A saw Dr N for a review of her wound and follow-up of the wound swab taken on 13 Month4. Dr N noted: “Came for review after wound swab and further management. Still has infection and greenish discharge. Stable, alert, conscious. Nil distress.” He prescribed Mrs A mupirocin ointment[29] and erythromycin tablets[30] for her wound infection.

71. On 20 Month4 DN C visited Mrs A and noted that she had seen Dr N, who had prescribed her oral antibiotics and mupirocin. DN C cleansed and redressed Mrs A’s wound with Aquacel AG, gauze and Micropore. She arranged for Mrs A to be seen again by the DNS on 24 Month4.

72. On 24 Month4 a DN visited Mrs A and applied mupirocin to her wound and redressed it with Aquacel AG and gauze.

73. On 27 Month4 DN I visited Mrs A, noting that her wound was “very small” and hypergranulated, and that she had completed the course of antibiotics. DN I treated Mrs A’s wound with silver nitrate to assist in reducing the hypergranulation.

74. On 29 Month4 DN J visited Mrs A and recorded having redressed her wound with Aquacel AG. DN J told HDC that Mrs A “complain[ed] of very mild pain” when removing the dressing. DN J further stated that the wound was “superficial” and did

[28] Micropore tape is a latex-free, hypoallergenic paper tape.
[29] An antibiotic used to treat bacterial skin infections.
[30] An antibiotic used to treat bacterial skin infections.

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not require packing, and that there were no signs of infection; however, this is not documented.

Referral to Dr N

75. On 31 Month4 DN C visited Mrs A again. DN C cleansed Mrs A's wound and applied mupirocin before redressing it with gauze and Micropore. DN C noted that there was an increased amount of green exudate from Mrs A's wound, and that she had advised Mrs A to obtain more antibiotics from her GP and "to tell GP it is urgent". DN C also noted: "Pt getting upset at how long healing is taking." She arranged for the DNS to revisit Mrs A on 4 Month5 and referred Mrs A to Dr N.

Third consultation with Dr N

76. On the same day, 31 Month4, Mrs A saw Dr N, who took a swab of her wound to check for infection and noted:

> "1. Referred by district nurse.
> 2. Ongoing discharge from breast abscess …"

77. Dr N prescribed Trisul[31] tablets and arranged to review Mrs A in a week's time for a possible referral to a specialist.

78. On 4 Month5 DN E visited Mrs A and noted that she had a "pocket of fluid" underneath her wound, that there was an increased amount of green exudate, and that the wound was hypergranulated. DN E noted: "Advised to See GP & get a referral to see surgical team." DN E noted that she cleansed and redressed Mrs A's wound with Pimafucort, Cuticerin, gauze and Micropore.

Fourth consultation with Dr N

79. On 7 Month5 a DN visited Mrs A and redressed her wound with Pimafucort and Cuticerin. The DN told HDC that the wound appeared to be "superficial and healing".

80. That afternoon Mrs A visited Dr N as her wound was not improving. Mrs A's wound swab results showed a "light growth" of MRSA. Dr N noted: "[H]as ongoing discharge from [right] breast. Has on going growth of MRSA." Dr N considered it most likely that Mrs A had developed a sinus tract on her right breast. He prescribed Paracare[32] tablets and referred her to general surgeon Dr M at a private hospital.

Referral to Dr M

81. On 9 Month5 Mrs A attended a consultation with Dr M. Dr M noted:

> "On examination [Mrs A] was noted to have a discharging wound in her right breast at the 9'oclock position. Underneath, she had a firm lump which seemed to extend towards the nipple. Clinically I believe she has got an un-drained collection and a sinus formation."

[31] An antibiotic used to treat bacterial infections.
[32] Analgesia for mild to medium pain.

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82. Dr M advised Mrs A that she would require a further procedure to have the area excised. Dr M referred Mrs A for an ultrasound scan and booked her for surgery on 24 Month5.

83. On 10 Month5 DN C visited Mrs A to review her wound and cleansed and redressed the wound with Pimafucort, Cuticerin and gauze. DN C noted that Mrs A had seen a specialist with regard to her wound and would be having surgery in two weeks' time. DN C arranged for the DNS to see Mrs A in a week's time, prior to her surgery.

84. On 11 Month5 Mrs A underwent an ultrasound scan. The ultrasound showed a "2.3 x 2.3 x 1.6cm fluid collection".

85. On 17 Month5 DN E visited Mrs A and noted that the wound was looking "very mucky". DN E redressed Mrs A's wound with Cuticerin and gauze and arranged for the DNS to see her again after her surgery.

Wound excision

86. On 24 Month5 Dr M performed an excision of Mrs A's wound. Following the procedure Mrs A was told that her wound had not been healing because it had contained a 5cm foreign body, which was later identified as a piece of Aquacel rope dressing.

Follow-up

87. Following her surgery Mrs A continued to receive visits and wound dressing by the DNS. On 29 Month5 DN J visited Mrs A and was told of the findings from the surgery five days earlier. DN J informed Charge Nurse Manager DN L of the findings.

88. Mrs A had a follow-up consultation with Dr M, who noted that there was "general hardness" in Mrs A's wound, but that this had improved in the previous two weeks. Dr M prescribed a further course of erythromycin and discharged Mrs A into the care of Dr N.

89. Mrs A's wound healed successfully over the next month and the DNS noted that the wound had healed.

Further information from ADHB

90. With regard to Mrs A's initial home visit and assessment, ADHB informed HDC that following an initial assessment of a new patient it is normal practice for a district nurse to discuss triage with a designated senior district nurse. ADHB said that such a discussion did not occur with regard to Mrs A and, furthermore, Mrs A was not reviewed "holistically", as only her wound was reviewed. It stated that had a holistic review been undertaken (taking into consideration other existing social and cultural factors), Mrs A may have been assessed as having a moderate acuity rating, which would have put the district nurses on notice that Mrs A had other health and personal factors to take into consideration in the course of her treatment.

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Actions taken as a result of these events

91. Following these events a formal investigation was carried out by a nursing advisor and the Charge Nurse, District Nursing Services, DN L.

92. As part of the investigation, ADHB assessed the use of Aquacel rope. ADHB told HDC that the correct use of Aquacel rope is for the end of the rope to be left outside the wound, and it appears that the end was not always visible when the district nurses visited Mrs A, and that DNS staff assumed that Mrs A had removed her dressing while showering.

93. According to ADHB, when the end of the Aquacel rope is not visible, it is usual practice for the district nurse to question the patient, investigate the wound with a probe, and document the results of the investigation. ADHB stated: "It appears this was not the case during Mrs A's care."

94. Furthermore, ADHB stated:

> "Due to limited documentation in the nursing notes it is unclear when, during the treatment period, the Aquacel rope was retained. It is usual practice to probe a sinus wound prior to redressing and record the depth however it is not documented that this practice was applied consistently."

95. Further findings of the investigation included:

> "Wound documentation is evident, but lacking in detail in relation to descriptors of wound depth, measured length of dressing/packing and removal of dressing type/product.
>
> Regular product change occurred without peer review."

96. As a result of the investigation the DNS has reviewed:

- the primary nursing model of care including patient allocation and frequency and consistency of nursing visits;
- the documentation practice using audit;
- the supervision and peer feedback model for district nurses;
- the communication between secondary and primary health in relation to follow-up information from consultations; and
- the complaints escalation process.

97. In addition, the senior nursing leadership team at the DNS will ensure that staff are reminded of the requirement for comprehensive holistic assessment. ADHB is also considering the introduction of electronic record-keeping within the DNS. This is currently being used within the clinic before being piloted in the home visit setting.

98. ADHB has introduced the use of a wound depth probe (a device that measures the sinus depth) into standard practice at the DNS.

99. ADHB has apologised to Mrs A and her husband.

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Relevant ADHB policies

100. ADHB stated that at the time of these events it did not have a policy regarding probing and/or measuring of wounds, or keeping account of foreign bodies and recording the amount and type of wound care products used, as it had considered this to be part of a nurse's professional training.

101. However, since these events it has introduced a policy: *SOP — Pilonidal Sinus/abscess*, which states:

> "… 3. Referral for pilonidal/abscess cares is received and triaged, home visit initially for first 3–5 days then patient to attend clinic.
> …
>
> 5. Patient should be encouraged to shower or bath prior to DN visit or attending clinic.
> …
>
> 7. Each dressing change the nurse must ensure packing is removed and documented this has occurred.
>
> 8. Measurement of the wound must occur at each dressing change using a visitrak[33] depth probe. This must be documented.
>
> 9. The type of packing inserted and amount must be documented in the clinical notes. …"

102. The policy *Nursing Documentation for Adult Patients* (2012) states:

> "2. Policy Statements
>
> The objective of nursing documentation is to provide a concise, legible, complete and accurate record of relevant assessment, interpretation of findings, plan of care and evaluation of care provided to the patient as appropriate to the clinical environment.
>
> Nursing documentation includes:
>
> Nursing entries in the patient's clinical record. The clinical record holds entries by all health care providers contributing to the care of the patient. Nursing entries include a record of care provided and evaluation.
>
> A–D Planner
> All assessment tools eg falls, pressure injury, VTE assessment
> Care plans
> Discharge plans
> Observation Charts
> Fluid Balance Charts

[33] A brand of depth probe for measuring the depth of wounds.

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Nursing entries on the Medication Charts, Diabetes Charts and Anticoagulant Charts.

…

Frequency

Documentation of an initial nursing assessment and plan of care is to commence within 2 hours of admission to a clinical area, and completed within 12 hours.

Documentation of care and evaluation of nursing care is to be as close as possible to the time the care was performed and at least once per shift.

Documentation of vital signs and additional assessment observations are to be recorded directly onto the appropriate charts at the time undertaken.

Documentation of discharge planning is to commence within 12 hours of admission …"

Response to Provisional Opinion

Auckland District Health Board

103. In response to the provisional opinion ADHB advised that "[t]he District Nursing team have accepted the findings and recommendations and have apologised for the management of the adverse event."

104. ADHB also stated:

"ADHB also accepts the findings that its allocation of cases, care continuity, and standard operating procedures, as exposed in this case, are not aligned, and that a full review of policy, standard operating procedures and process has been undertaken. The wound care policy has been reviewed, along with a local policy review of the allocation and continuity of care [standard] operating procedures that have subsequently been refreshed and changes implemented."

105. ADHB stated:

"Auckland District Health Board is committed to providing a high standard of service and strives to deliver the best quality of care for all patients. We offer our sincere apologies to [Mrs A] for our failure in this regard."

106. ADHB advised that in addition to the recommendations of the provisional report:

"ADHB has undertaken a review of the District Nursing Service's current clinical practices and is working with the senior leadership to ensure confidence that the service delivery model is safe and appropriate to patient needs. Concurrently, a community nursing workforce development plan has commenced, underpinned by the ADHB's nursing strategy."

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Opinion: Auckland District Health Board — Breach

Preliminary matters

107. For the avoidance of doubt, during my investigation no concerns were raised regarding the standard of care Dr N provided to Mrs A. Accordingly, this decision relates solely to the care provided by the ADHB District Nursing Service.

Introduction

108. Following the incision and draining of Mrs A's breast abscess on 15 Month2 she was seen by at least 12 ADHB district nurses over the next three months. In my view, some aspects of the care received by Mrs A during this period were suboptimal. Individual district nurses who provided care to Mrs A hold a degree of responsibility for the suboptimal care at various times. However, as stated in previous opinions of this Office,[34] DHBs are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures. ADHB had an organisational duty to ensure that care was provided with adequate care and skill. Taking into account the number of district nurses involved in Mrs A's suboptimal treatment, I consider that ADHB holds primary responsibility at a systems level for the poor standard of care provided.

Triage rating

109. Mrs A gave birth to her first child by forceps delivery and suffered a third degree tear, which resulted in urinary and faecal incontinence. Mrs A, who had limited family support in New Zealand, was unable to leave the house easily as a result.

110. On 15 Month2 Mrs A underwent surgery to have a breast abscess drained. On 16 Month2 she was discharged and referred to the DNS for ongoing wound care. That day, the DNS received the referral and DN D triaged Mrs A as having a "low acuity rating", indicating that she required simple wound care with no perceived complications. Mrs A's triage form contains no reference to her other health issues or her social and cultural factors, including that she had no family in New Zealand other than her husband, and that she was unable to leave the house easily because of the incontinence suffered as a result of her labour.

111. My expert nursing advisor, RN Julie Betts, stated that current standards of practice would include patients being assessed for their potential to heal holistically rather than the predominant factor being the wound presentation or type. Ms Betts advised:

> "Inherently this would require that processes exist in DNS that facilitate both holistic assessment of patients, and escalation of care/case review in situations where there is a delayed healing or deterioration in the wound."

112. Ms Betts noted that the ADHB DNS screening tool categorises patients according to complexity, but lacks the requirement for specific information that would indicate potential problems for delayed healing. She stated that in Mrs A's case there were key

[34] Opinion 10HDC00703 and 10HDC00419, available at www.hdc.org.nz.

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indicators, including physical, psychological, social and cultural issues, that increased her level of complexity and potential for delayed healing. ADHB stated that, following an initial assessment of a new patient, normal practice was for the district nurse to discuss the triage with the designated senior district nurse. ADHB stated that such a discussion did not occur, and agreed that Mrs A was not reviewed holistically during her initial assessment, as only her wound was reviewed. In this respect, ADHB stated that if a holistic review had been undertaken Mrs A may have been assessed as having a moderate acuity rating.

113. I am critical that during the triage assessment there does not appear to have been any consideration of Mrs A's other health issues or social and cultural factors. I agree with my expert that Mrs A's triage assessment should have included a holistic assessment of factors that would impact on healing. I am critical that this did not occur. I am also critical that the ADHB DNS screening tool categorises patients according to complexity, but lacks the requirement for specific information that would indicate potential problems for delayed healing.

Use of Aquacel rope

114. On 17, 18, 19 and 20 Month2 the district nurses used Aquacel rope to pack Mrs A's wound. ADHB stated that when packing a wound with Aquacel rope, the end of the rope should be left outside the wound. However, according to ADHB, the end of the rope was not always visible when the district nurses visited Mrs A.

115. ADHB stated that at the time of these events it did not have a policy regarding keeping account of foreign bodies and recording the amount and type of wound care products used, as it considered this to be part of a nurse's professional training. In this respect, ADHB stated that usual practice, if the end of the Aquacel rope is not visible when redressing a wound, is for the district nurse to question the patient, investigate the wound, and document the results of the investigation. ADHB agreed that these actions did not occur during Mrs A's care, and stated that its staff assumed that Mrs A had removed her dressing while showering. However, Mrs A told HDC that she did not shower until approximately four weeks after the district nurses began visiting her home, and never removed her own dressings.

116. In this respect, Ms Betts advised that "recording product amount and type is considered standard practice nationally and internationally and has been for at least 10 years". In my view, it is concerning that the district nurses in this case would assume that a patient had removed her own dressings without further investigation or discussion with the patient. I am concerned that a number of district nurses appeared to have made similar errors in this regard.

117. Because of the poor record-keeping and the limited assessments of Mrs A's wound by the district nurses, it is unclear when the Aquacel rope was left in the wound, or by whom. However, an error occurred when a nurse failed to remove the Aquacel rope from Mrs A's wound on either 18, 19 or 20 Month2.

118. It is concerning, first, that Aquacel rope was left in Mrs A's wound and, secondly, that a number of staff failed to identify the error. When the end of the Aquacel rope was

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not visible when Mrs A's wound was redressed, the nurses failed to follow good practice by first checking with Mrs A as to whether she had removed the dressings herself, and then by investigating the wound and documenting the results of that investigation.

Ongoing wound assessments

119. ADHB district nurses documented their assessments of Mrs A's wound in her clinical notes, or in the ADHB Wound Care Assessment form. After 17 Month2 there is no objective record of the dimensions of Mrs A's wound. Although there are comments in the clinical notes about the healing of the wound, there is no quantifiable or objective measure of the wound or its healing.

120. The ADHB Wound Care Assessment form has tick boxes for wound type, appearance of the wound, exudate, surrounding skin, and nutritional status. However, according to Ms Betts, "the DNS wound assessment forms fail to provide the ability to record objective parameters that would indicate wound progress over time". Furthermore, while objective measures such as wound measurements or wound health were recorded by the district nurses on some occasions (either in the clinical notes or in the wound assessment form), this was not done consistently.

121. ADHB advised that, at that time, it did not have a policy regarding probing and/or measuring wounds, as it considered this to be part of a nurse's professional training. In this respect, Ms Betts advised:

> "[A]ssessing wounds including measuring dimensions (length, width and depth) … is considered standard practice … Whether or not policy detailing DHB expectations was in place at the time of the events doesn't change what would be considered contemporary practice at the time and a reasonable expectation of nursing practice."

122. Ms Betts advised that the nursing assessments undertaken by each district nurse were not consistent with accepted standards of practice. Ms Betts stated:

> "Recording wound dimensions is considered to be a fundamental outcome indicator of the progress of healing and has been a commonly accepted practice in wound care for some time."

123. It is concerning that ADHB failed to ensure that its wound assessment form was designed to capture objective parameters that would indicate wound progress over time, and that district nurses frequently failed to record objective assessments of Mrs A's wound.

124. Ms Betts has advised that the failure to document the wound dimensions was a serious departure from accepted practice. She noted: "[T]he inability to review this information in a more objective and consistent method at regular time points, in my opinion, increases the risk of failing to notice in a timely manner wounds that are not responding to treatment." I agree and am critical that there was no regular and

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objective recording of the dimensions of Mrs A's wound in the clinical notes by the district nurses, and no apparent requirement by ADHB for such documentation.

Peer review and escalation of care

125. The district nurses made changes to the products being used to treat Mrs A's wound regularly. From 17 Month2 to 20 Month2, Aquacel rope was used with gauze. On 20 Month2, Aquacel Ag was also used and, on 21 Month2, Aquacel Ag and Hyperfix were used. Between 22 Month2 and 31 Month2, ribbon gauze and gel were used. However, the reasons for each change of product are not recorded adequately, and there is no record that peer review was obtained on any of these occasions.

126. Furthermore, on 2 Month3, DN F trialled Pimafucort and Cuticerin and redressed Mrs A's wound with gauze and Hyperfix. On 4 Month3 DN C applied an Aquacel dressing with Flamazine, and dressed the wound with gauze and Hyperfix. On 11 Month3 DN C trialled Acticoat Flex and Hyperfix. On each occasion the products used were changed again the following day, and there is no record of the efficacy or the outcome of each treatment.

127. Ms Betts advised that the standard of peer review in Mrs A's case was not consistent with accepted standards of practice. She noted that internal processes to escalate Mrs A's care to a senior nurse when her wound failed to heal were not followed.

128. On several occasions the district nurses advised Mrs A to consult her GP. On 21 Month3 DN O assessed Mrs A's wound, noting hypergranulation and redness and that Mrs A's pain had increased. DN O advised Mrs A to see her GP owing to concerns about a recurring infection.

129. On 10 Month4 DN C advised Mrs A that she should discuss the possibility of an MRSA infection with her GP. On 13 Month4 DN C swabbed Mrs A's wound and, on 17 Month4, she contacted Dr N to obtain the swab results, which showed MRSA. DN C noted that Mrs A would see Dr N to obtain oral antibiotics. On 17 Month4 Mrs A saw Dr N, and he prescribed oral antibiotics and mupirocin.

130. On 31 Month4 DN C noted that there was an increased amount of green exudate from Mrs A's wound, and advised her to contact her GP to arrange further antibiotics.

131. On 4 Month5 DN E noted that there was an increased amount of green exudate and the wound was hypergranulated. DN E advised Mrs A to see her GP for a referral to the surgical team. Consequently, on 7 Month5, Mrs A consulted Dr N, who referred her to Dr M.

132. Ms Betts advised that the referrals to the GP for review were appropriate escalations of care, but stated that, in her view, on 21 Month3, the district nurse should have directly communicated her concerns and assessment findings regarding Mrs A's wound to Dr N directly, instead of relying on Mrs A to do so herself.

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133. I agree that the referrals to Mrs A's GP were appropriate escalations of care. However, I am concerned that at times the district nurses relied on Mrs A to contact her GP rather than contacting the GP directly.

134. I am also concerned that the district nurses were making regular changes to the products used, for no documented reason, with no peer review, and no apparent follow-up of the efficacy of the treatment provided.

135. In my opinion, ADHB should have ensured that appropriate systems were in place so that its staff were required to implement peer review and escalate care directly to an appropriate provider in situations where there was delayed healing or deterioration in a wound.

Conclusion

136. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures. In my view, it was the responsibility of ADHB to have in place adequate systems and appropriate oversight of staff in order to ensure that Mrs A received appropriate care. I consider the failures of the district nurses to be service-level failures that are directly attributable to ADHB as the service operator. The failures by ADHB, outlined below, demonstrated a pattern of suboptimal care.

137. The ADHB DNS screening tool categorises patients according to complexity, but lacks the requirement for specific information that would indicate potential problems for delayed healing, and, during the triage assessment, there was no consideration of Mrs A's social and cultural factors, and her ability to heal holistically. The failure by a number of district nurses to keep adequate records of Mrs A's treatment, ask her the appropriate questions, and investigate the wound appropriately, led to a length of Aquacel rope being left undetected in Mrs A's breast wound. In my view this was unacceptable, and resulted in delayed healing and increased pain and distress for Mrs A. However, because of the poor record-keeping I have been unable to determine the full circumstances under which the product was left in Mrs A's breast. Also, the ADHB wound assessment form was not designed to capture objective parameters that would indicate wound progress over time, and district nurses were not recording objective assessments of Mrs A's wound consistently. Accordingly, ADHB failed to ensure that services were provided to Mrs A with reasonable care and skill and breached Right 4(1).

138. By at times relying on Mrs A to contact her GP rather than the district nurse contacting the GP directly; by making regular changes to the products used without documenting the reason; and by having no peer review and no recorded follow-up of the efficacy of the treatment provided, the district nurses failed to work together effectively. Accordingly, ADHB failed to ensure cooperation among providers to ensure quality and continuity of services to Mrs A, and breached Right 4(5)[1] of the Code.

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Recommendations

139. In accordance with the recommendations of the provisional report Auckland District Health Board has agreed to:

a) Provide a formal written apology to Mrs A for its breaches of the Code. The apology is to be sent to HDC within **three weeks** of the date of this report, for forwarding to Mrs A.

b) Provide an update of progress regarding the possible introduction of electronic record-keeping within the District Nursing Service. The update is to be sent to HDC within **three weeks** of the date of this report.

c) Undertake an independent peer review of the quality of Auckland District Health Board District Nursing Service wound assessment and evaluation, and the documentation thereof, for a random selection of patients cared for in the last six months. The review is to be sent to HDC within **three months** of the date of this report.

140. In my provisional opinion I also recommended ADHB provide an update regarding the implementation of changes made following the review carried out in light of this incident. In response to my provisional opinion ADHB advised that it has undertaken a "full review of policy, standard operating procedures and process", and that the wound care policy, together with a local policy review of the allocation and continuity of care standard operating procedures have been "refreshed" and changes implemented.

141. I further recommend ADHB provide a report to HDC confirming the implementation, or planned implementation, of any changes made following its reviews, including evidence of the communication of these changes to staff and any associated education provided. The update is to be sent to HDC within **three months** of the date of this report.

Follow-up action

142. A copy of this report with details identifying the parties removed, except Auckland District Health Board and the expert who advised on this case, will be sent to the New Zealand Nurses Organisation, the New Zealand Wound Care Society Inc, the New Zealand Nursing Council, and the College of Nurses Aotearoa Inc and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Julie Betts:

> "I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am currently registered as Nurse Practitioner with a specialty in wound care. I have a total of 34 years nursing experience. The first seventeen years of my nursing career I was employed as a registered nurse working in both hospital and community practice settings. In 1997 I was employed into a specialist nursing role with a wound care focus. In 2003 I registered as a nurse practitioner wound care and have continued in that position for the last eleven years. As a nurse practitioner, the focus of my role is providing expert clinical advice and management of patients with complex wounds across primary and secondary services, both in delivering direct patient care and service development to support best practice and improve patient outcomes.
>
> My professional qualifications include registration as a General and Obstetric Nurse and Nurse Practitioner. My academic qualifications include, Advanced Diploma of Nursing, Post Graduate Diploma in Health Science, Certificate of Proficiency (prescribing) and Master of Nursing.
>
> **Advice requested**:
> I have been asked to provide expert advice on the care [Mrs A] received from the Auckland District Nursing Service (DNS) between 17 [Month2] and 27 [Month5] with particular reference to:
>
> - The quality of nursing assessment undertaken
> - Whether DNS responded appropriately to [Mrs A's] complaint of non healing and pain
> - The standard of peer review.
>
> **Information reviewed:**
>
> - Letter of complaint
> - ADHB's response
> - [Hospital] notes from 13 [Month2] to 16 [Month2]
> - DNS notes from 16th [Month2] to 2nd [Month2]
> - GP's notes
> - Notes from General Surgeon, [Dr M]
> - Subsequent documents requested from ADHB regarding wound care policies, procedures or guidelines
>   - Wound product practice guideline
>   - Wound infection
>   - Wound care instructions for patients and families
>   - Wound assessment
>   - SOP pilonidal and abscess wound document
>   - Fact or fiction
>   - Phases of wound healing
>   - District nursing wound assessment
>   - Clinical records nursing documentation

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Summary:
[Mrs A] developed a lactational breast abscess which was incised and drained on 15th [Month2]. [Mrs A] was subsequently referred to the DNS, and had her wound packed on a regular basis. She noticed that her wound was slow healing, and she complained of swelling, excessive pus and intense pain. [Mrs A's] GP referred her to a general surgeon, [Dr M], who performed an excision biopsy on 24th [Month5]. During the procedure [Dr M] found a 3x4 cm cystic lesion and a 5 cm piece of wound dressing material (later identified as Aquacel rope) in the cavity.

Response to questions posed:

1. The quality of nursing assessments undertaken by each district nurse
My opinion on the quality of nursing assessments undertaken by each district nurse is that the nursing assessments as they relate to wound care are not consistent with accepted standards of practice. My main reason for coming to this conclusion is the lack of any record of measurement of the dimensions of [Mrs A's] wound throughout her care. Recording wound dimensions, is considered to be a fundamental outcome indicator of the progress of healing and has been a commonly accepted practice in wound care for some time[1,2]. While there are recorded comments in the clinical notes such as 'wound healing' there is no quantifiable or objective measure of this. A failure to document this observation during the period of time [Mrs A] was under the care of DNS in my view would be considered a serious departure from accepted practice.

I would also like to note that in reviewing the documentation provided, the DNS wound assessment forms fail to provide the ability to record objective parameters that would indicate wound progress over time. Such parameters would normally include observations on wound dimensions, stage of healing, exudate level and type, level of pain, and observations of the health of the surrounding skin. Some of these parameters can be found in the visit entries made at each district nurse visit. However, the inability to review this information in a more objective and consistent method at regular time points, in my opinion increases the risk of failing to notice in a timely manner wounds that are not responding to treatment. The lack of recording of wound dimensions and methods to record objective parameters of healing over time would be viewed by my peers with moderate to severe disapproval.

2. Whether DNS responded appropriately to [Mrs A's] complaint of non-healing and pain
The response by DNS to [Mrs A's] complaints of increasing pain and non-healing of the wound in my view is in keeping with current standards of practice.

Recorded reports of [Mrs A's] increasing pain and non-healing were escalated to [Mrs A's] General Practitioner (GP) who subsequently reviewed [Mrs A] within 24–48 hours. In DNS the expected pathway for escalation of care for increasing pain and non-healing of wounds would be to the GP. It would also be expected that complaints of increasing pain and non-healing would be escalated as soon as possible which appears to have occurred in this case. The response by DNS in this matter would also be viewed by my peers as acceptable practice.

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3. The standard of peer review
My opinion on the standard of peer review is that it is not consistent with accepted standards of practice. My reasons for this are that current standards of practice would include patients being assessed for their potential to heal holistically, not based on the wound presentation, or type, as the predominant factor. Escalation of care or case review would be driven by delayed healing or deterioration in the wound which could be seen by a change in patient symptoms, wound characteristics, or failure to heal in a normally expected time frame for the type of wound. Inherently this would require that processes exist in DNS that facilitate both holistic assessment of patients, and escalation of care/case review in situations where there is delayed healing or deterioration in the wound.

While the DNS have a screening tool to categorise patients according to complexity, the tool lacks specific information that would indicate potential problems for delayed healing. In [Mrs A's] case there were key indicators including physical, psychological, social and cultural issues that would increase her level of complexity and potential for delayed healing. Taking these factors into consideration an initial assessment would have resulted in assigning medium complexity to [Mrs A] resulting in regular formal case review. Additionally, internal processes to escalate [Mrs A's] care to a senior nurse when her wound failed to heal did not occur. Despite this, it is clear the DNS were concerned that [Mrs A's] wound was not responding to treatment and they believed infection might be the problem. They advised [Mrs A] to see her GP initially on 21st [Month3] and again on 17th and 31st [Month4], and 4th [Month5]. Referral to the GP for review in itself is an escalation of care. Having said that, it does not appear that the DNS discussed their concerns regarding problematic wound healing with the DNS but instead relied on the patient to do this. It would be a reasonable expectation that if DNS was advising the patient to see their GP for a matter they were concerned about, that they would also discuss their assessment findings and concerns with the GP. It is possible that if DNS had discussed their concerns with the GP, proactive action to identify the reasons for delayed healing may have been taken earlier. For these reasons my view is that the standard of peer review is a moderate departure from current practice. It is also my view that my peers would view the standard of peer review in [Mrs A's] case with moderate disapproval.

Additional comments
In reviewing this case there is another issue I have noticed that I believe requires comment. That is the use of apparently un-prescribed topical medication.

During [Mrs A's] care DNS used both Flamazine and Pimafucort intermittently as topical antibiotics and anti-inflammatories to treat what they believed was either bacterial infection, seen as green exudate, or hyper granulation. It appears from the clinical record that neither of these medications were prescribed. The only apparent prescribed topical antibiotic was the use of mupirocin to treat a Methicillin resistant Staphylococcus Aureus infection, determined by wound culture, and given in combination with systemic antibiotics by [Mrs A's] GP. The use of topical antibiotics without evidence of discussion with, or prescribing by an authorised prescriber is neither legal, nor best practice.

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There is little research to quantify the exact cause of hyper granulation of a wound. Clinical experience indicates that increased bacterial burden is a contributing factor and that application of a combined topical antibiotic and anti-inflammatory agent does reduce hyper granulation effectively. However this is usually applied as a last resort not as a first response. The reason for this is not just to reduce the risk of bacteria developing antibiotic resistance, but also to exclude other reasons for hyper granulation such as a non-draining fluid collection or unhealthy tissue at the base of the wound. The choice of DNS to apply topical medication to a patient where the medication has not been prescribed should follow documented discussion with an authorised prescriber as to the reasons why the medication is required and agreement that it is an acceptable course of action.

In my opinion the apparent routine use of un-prescribed topical medications in DNS to treat infection and hyper granulation warrants further investigation, to identify reasons for this practice in order to address what may be an educational need."[35]

On 6 August 2015 Ms Betts provided the following further advice to the Commissioner:

"This report is in response to further advice requested by the commissioner in relation to the nursing care provided to [Mrs A] by ADHB district nursing service.

Advice requested:
Further advice regarding my concerns on the use of topical medications during [Mrs A's] care, and escalation of [Mrs A's] care to the GP.

Information reviewed:

- HDC summary of the facts gathered during the investigation regarding [Mrs A] care

Response to questions posed:
1. Whether my advice and concerns regarding the use of topical medications has changed in light of the information provided in the summary.
After reviewing the details provided in the summary of facts, my initial advice and concerns regarding the use of the topical medications Flamazine and Pimafucort by the district nurses in this case is largely unchanged. My reason for coming to this conclusion is that in only one instance (on the 21st of [Month3]) it is clear [Mrs A's] GP prescribed Pimafucort to treat her wound. In all other instances it is either disputable whether the topical medications were prescribed, or clear that they were not prescribed. It concerns me that the majority of the time that the district nurse decided to apply prescription only topical medication to [Mrs A's] wound it was done without due diligence.

2. Clarification of my advice regarding occasion(s) that I considered the DN(s) should have spoken to [Mrs A's] GP directly, rather than advising [Mrs A] to contact him, in light of the summary of facts gathered.

[35] These concerns have been dealt with separately.

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After review of the details provided in the summary of the facts, there is only one instance on the 21st [Month3] where I believe the DN should have directly communicated their concerns and assessment findings regarding [Mrs A's] wound to her GP instead of advising [Mrs A] to do so."

On 13 October 2015 Ms Betts provided the following further advice to the Commissioner:

"This report is in response to further advice requested by the commissioner in relation to the nursing care provided to [Mrs A] by ADHB district nursing service.

Advice requested:
The appropriateness or otherwise of ADHB's advice that at the time of the events it did not have any policies in place regarding;

a) probing and/or measuring wounds; or
b) keeping account of foreign bodies/wound care products used during wound care

Information reviewed:
- HDC summary of the facts gathered during the investigation regarding [Mrs A's] care
- HDC office correspondence summarising ADHB's implementation of pilonidal sinus/abscess SOP, including requirements regarding wound measurement, and recording type and amount of packing inserted into sinus wounds.

Response to advice sought:
After reviewing the details provided in the summary of facts and correspondence, my advice as to the appropriateness or otherwise of ADHB's advice related to the absence of policies at the time of the event, does not alter my original opinion as to the standard of nursing care. My reason for this is that assessing wounds including measuring dimensions (length, width and depth) and recording product amount and type is considered standard practice nationally and internationally and has been for at least 10 years. Whether or not policy detailing DHB expectations was in place at the time of the events doesn't change what would be considered contemporary practice at the time and a reasonable expectation of nursing practice.

It is encouraging to see that ADHB has implemented a policy specific to measuring sinus and recording type and amount of product inserted into sinus/abscess. In my opinion combining this with the ability for nursing staff to document such information in a format that enables objective recording and reviewing of data over time, is more likely to facilitate objective assessment and documentation of wound care.

References:
1. Templeton, S. (2005). (Ed.). Wound care nursing: A guide to practice. Melbourne, Australia: Ausmed Publications Pty Ltd.
2. Sussman, C., & Bates-Jensen, B. (2013). (Eds.). A collaborative practice manual for health professionals. (4th ed.) Baltimore, MD: Lippincott, Williams & Wilkins."

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