Wound management by district nursing service (14HDC00766, 17 June 2016)

District Health Board ~ District nursing service ~ Wound management ~ Rights 4(1), 4(5)

A woman, who had recently given birth to her first child, developed an abscess in her breast. The woman underwent surgery to have the abscess drained and was subsequently referred to the district nursing service for ongoing management of her wound. The wound was packed with a wound dressing called Aquacel rope. The end of the rope should remain outside the wound. However, when the end of the rope was not visible it was assumed that the woman had removed the rope herself, when she had not done so.

The wound was slow to heal but there was no objective record of the dimensions of the wound. The district nurses made regular changes to the products being used to treat the wound, but the reasons for each change of product were often not recorded. At times the district nurses relied on the woman contacting her general practitioner (GP) for review rather than making the contact for her.

When the wound was noted to have hypergranulated with an increased amount of green exudate the woman was told to see her GP to obtain a referral to the surgical team. During surgical excision of the wound a 5cm piece of Aquacel rope dressing was discovered.

The district nursing service's screening tool categorised patients according to complexity, but lacked the requirement for specific information that would indicate potential problems; the triage assessment lacked consideration of social or cultural factors that could impact on healing.

The Aquacel rope was not used appropriately and the wound was not investigated adequately. In addition, the District Health Board (DHB) 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 the woman's wound consistently. Accordingly, the DHB failed to ensure services were provided with reasonable care and skill and breached Right 4(1).

By relying at times on the woman 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, the DHB failed to ensure cooperation among providers to ensure quality and continuity of services and breached Right 4(5).

Following this event the DHB undertook a review of policy, standard operating procedures and process and implemented changes. The Commissioner recommended that the DHB 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. The DHB 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.