Rest Home

Registered Nurse, RN H

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC01232)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A was a hospital-level resident at a rest home. Registered nurse (RN) RN H was the Clinical and Nurse Manager at the rest home.

2. In Month1[1], Mrs A developed pressure areas on her heels and sacrum. Over the following months, the wounds were assessed regularly and the conditions described on wound care plans by various rest home staff. The sacral wound descriptions were sometimes contradictory in respect of how well the wound was healing.

3. There are different versions of events regarding the number of attempts made by RN H to contact the district health board (DHB) wound care specialist for advice on managing the pressure areas.

4. Mrs A was reviewed at the rest home regularly by general practitioners (GPs) from the medical centre, but the sacral wound was not reviewed physically by a GP until 16 Month4, when it was noted to be at risk of infection, and antibiotics were prescribed.

5. On 23 Month4, Mrs A was transferred to the public hospital where, sadly, she died in the Emergency Department from sepsis secondary to a chest infection and a necrotic sacral ulcer.

Findings

6. The rest home owner 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). It was found that:

- The descriptions of Mrs A's sacral wound in the wound care plans, made by various staff, were inaccurate and inconsistent over a period of approximately three months;
- The wound care policy and form that were used did not guide staff to assess wounds objectively, and were inadequate. This contributed to inaccurate and inconsistent wound descriptions by staff; and
- Rest home staff did not provide the GPs with full and accurate information to enable them to make sound, accurate decisions.

7. Overall, the Deputy Commissioner did not consider that the care provided to Mrs A by the rest home owner was adequate. Accordingly, it was found that the rest home owner did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[2]

8. Adverse comment was also made about the management of the rest home and the communication with Mrs A's family.

9. While RN H was not solely responsible for the wound care that was provided to Mrs A, as the Clinical and Nurse Manager she was responsible for the clinical oversight of other staff,

[1] Relevant months are referred to as Months 1-4 to protect privacy.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

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and for ensuring effective nursing care. It was found that RN H should have done more to advocate for Mrs A and ensure that she received appropriate wound care. In all of the circumstances, the Deputy Commissioner did not consider that RN H provided care to Mrs A with appropriate care and skill and, accordingly, breached Right 4(1) of the Code.

10. Other comment was made that based on the information available to the GPs at the time of the reviews (in particular, on 14 Month2 and 6 Month4), it was acceptable that they did not review Mrs A's sacral wound physically.

11. Comment was also made about the different versions of events regarding what was communicated between RN H and the DHB wound care specialist.

Recommendations

12. It was recommended that the rest home owner arrange training for its staff on wound care, effective communication with family members, clinical documentation skills, and effective communication with GPs and other clinical personnel.

13. It was recommended that the rest home owner and the DHB work together to agree on a standard process for requesting advice from the DHB specialist wound care team.

14. The rest home owner and RN H each provided a written apology to Mrs A's family, as recommended in the provisional opinion.

Complaint and investigation

15. The Commissioner received a complaint from the family of the late Mrs A about the services provided by the rest home to Mrs A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by the rest home in 2015.*
- *The appropriateness of the care provided to Mrs A by RN H in 2015.*

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

17. The parties directly involved in the investigation were:

Mr A	Consumer's husband/executor/complainant
Ms B	Consumer's daughter/complainant
Mr C	Consumer's son/complainant
Ms D	Consumer's daughter/complainant
Mr E	Consumer's son/complainant
Ms F	Consumer's granddaughter/complainant
Rest home owner	
RN H	Registered nurse/Nurse Manager/Clinical Manager

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Also mentioned in this report:

RN G	Registered nurse
Mr M	Rest home director

18. Information was also reviewed from:

Medical centre	
Dr I	General practitioner
Dr J	General practitioner
District health board	
NP K	Nurse practitioner

19. Independent expert advice was obtained from registered nurse Jan Grant (**Appendix A**) and from HDC's in-house clinical advisor, general practitioner Dr David Maplesden (**Appendix B**).

Information gathered during investigation

Introduction

Mrs A

20. Mrs A, aged in her eighties, was initially admitted to the rest home for respite care in 2014. She was assessed later that month as requiring long-term hospital-level care. Mrs A was a hospital-level resident at the rest home until her death at the public hospital in 2015. Mrs A's next of kin, as recorded in the rest home admission documentation, was her husband, Mr A.

21. Mrs A's medical history included multilevel spinal stenosis,[3] mild dementia,[4] hypertension,[5] left foot drop,[6] neuralgia[7] in the feet and legs, and osteoarthritis.[8] From the time she entered the rest home, Mrs A was noted to be non-weight-bearing on both feet but she was able to mobilise with a wheelchair. Mrs A required two-person assistance for all transfers, and one-person assistance for showering, toileting and dressing. She used incontinence products for occasional incontinence, and a leg brace for her foot drop. Mrs A's Waterlow[9] pressure area risk assessment score was 28 on two occasions, indicating that she had a very high risk of developing pressure areas.

[3] A condition where the spinal canal narrows, which can cause pain and other symptoms.
[4] Dementia refers to a category of diseases that cause loss of memory and deterioration in other mental functions.
[5] High blood pressure.
[6] A gait abnormality in which the dropping of the forefoot happens because of weakness, irritation or damage to the common fibular nerve including the sciatic nerve, or paralysis of the muscles in the anterior portion of the lower leg.
[7] Pain often due to an irritated or damaged nerve.
[8] A type of joint disease that results from breakdown of joint cartilage and underlying bone.
[9] The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given patient. A score of 10–14 indicates "at risk". A score of 15–19 indicates "high risk", and a score of 20 and above indicates a very high risk.

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The rest home

22. The rest home is contracted by the DHB to provide rest-home and hospital-level care, but not dementia care, to residents. It is the only rest home facility in the town. In 2015, the rest home underwent a certification audit by HealthCERT (Ministry of Health). The audit states that the facility was able to provide care to up to 34 residents, and on the day of audit there were 28 residents. The audit report states: "[R]egistered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe." The auditors noted some areas for improvement that are not directly relevant to Mrs A's care.

23. The rest home also has a contract[10] with the medical centre, to provide medical services to the rest home. The contract states:

> "Our aim as a practice is to provide optimum medical care for our rest home residents in conjunction with [rest home] staff. We will try to provide some continuity in that a GP will be allocated to [the rest home] and will be the main person responsible for the medical care of those residents."

24. Dr I was the medical centre general practitioner (GP) attending the rest home regularly between 2006 and Month3 2015, at which time Dr J took over in this capacity. Dr I still provided cover for the facility when Dr J was on leave. At the time of these events, the rest home was attended twice weekly by a GP, and residents about whom staff had concerns were seen at that time. Routine medical reviews were carried out monthly for hospital-level residents, and three-monthly for rest-home-level residents.

25. The Clinical Manager and Nurse Manager of the rest home at the time of these events was RN H.

26. This report primarily relates to the care provided to Mrs A in respect of her pressure wounds. Numerous different nursing staff at the rest home were involved in dressing, evaluating, and completing documentation in relation to Mrs A's wounds.

Month1–Month2

27. A blister on Mrs A's left heel was first noted by nursing staff on 12 Month1, and a chronic wound care assessment and management plan (wound care plan) was commenced on 14 Month1 for "blisters on both heels due to shoes and [leg brace] rubbing on heels". The wounds were noted to be 8–10cm in diameter. Dr I was notified and, on 16 Month1, she reviewed Mrs A and documented in the clinical notes: "Plan; keep area protected until blister heals. For review if any signs of infection develop." It is documented that Mr A was asked to bring in some soft shoes for Mrs A and take home her other, ill-fitting, shoes.

28. A skin tear on Mrs A's sacral area[11] was noted by nursing staff on 16 Month1. A wound care plan was commenced on 17 Month1, listing the wound as pressure sores on the right and left side of the sacrum. The wound description is listed as "skin tear only (pressure sore)". The wound care plan states that the surrounding skin was intact and there was no wound odour. It states that wound one on the left side of the sacrum was 2cm x 1cm in size and wound two on the right side of the sacrum was 1cm x 1.5cm.

[10] Dated July 2013. The contract was updated in March 2016.
[11] The area at the bottom of the spine.

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29. The dressings, treatment, and evaluation of the above wounds were recorded on the wound care plans approximately daily by various staff.

30. On 20 Month1, the sacral wound care plan states that "the surrounding skin [was] fragile". On 22 and 23 Month1, the wounds are described as red in colour but with no signs of infection.

31. From 21 Month1 until 14 Month2, the sacral wounds are documented as being "slow healing".

32. On 28 Month1, Dr I reviewed Mrs A, and recorded:

> "[C]urrent issues; 1, blisters on heels. Left heel is healing very well. Right heel has broken down and has a pressure area. Not too deep, no signs of infection. 2, has sacral pressure sores (not examined) and is being made worse by urinary incontin[e]nce making the area constantly wet. x2 RNs have tried to catheterise with no success."

33. Dr I tried to insert a catheter but was also unsuccessful. She documented the following plan: "[P]ressure areas will need to be managed with regular position changing and more frequent pad changing."

34. With respect to the sacral pressure sore area, Dr I told HDC: "[T]he RN advised me during the ward round it was very small and I did not need to examine it." Dr I said that she told nursing staff that if any signs of infection were to develop, then they should contact a doctor.

35. Following this review, the dressings, treatment, and evaluation of the heel and sacral wounds were recorded on the wound care plans approximately daily by various staff. The heel wounds were noted to be "healing" then "healing well". The sacral wound was noted to be "healing slowly".

36. On 14 Month2, Dr I conducted Mrs A's monthly review. She made the following notes of the review:

> "[Mrs A's] heel areas are healing well but her sacral pressure area ([I] haven't ever seen it) is getting worse. They are changing her pads every 3hrs and regularly changing position. She often removes the dressings or scratches the area: [RN H] is referring to [Nurse Practitioner (NP) K].[12] [N]o other current concerns."

37. Dr I told HDC that she was told that Mrs A's sacral area was not improving. Dr I said that she requested an urgent referral to be made to NP K, and that RN H agreed to do this. Dr I stated: "In light of this referral I did not examine the sacral area as it was going to be reviewed by [NP K]."

38. RN H told HDC that she telephoned NP K to ask for further input. There is a handwritten record on a blank page in rest home notes stating:

[12] NP K is on the DHB's wound care team. The wound care team is a group of nurses working in advanced practice roles across the DHB. The team offers expert clinical advice, and works with a range of health professionals to achieve successful and cost-effective wound healing for patients in the area.

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> "14 [Month2] ph to [NP K] re: consultation re: sacral pressure. Try to catheterise if unable [to] change pads regularly. If necrosis areas use Cuticerin.[13] [Antibiotics] if wound looks infected. Lay flat as much as possible keep off sacral pressure. No need for air mattress."

39. NP K told HDC that she does not recall a conversation with RN H on 14 Month2. NP K stated that, if she did receive this telephone call, she is surprised that she would recommend catheterisation and the use of Cuticerin on a sacral pressure injury.

40. A short-term nursing care plan commenced on 14 Month2 by RN G states that both sacral wounds were not healing and were worse than previously, but that there were no signs of infection. The intervention required was to "change the current … care plan and need to initiate a dry wound dressing method using Aquacel[14]".

41. A new wound care plan was also commenced that day. It lists wounds one and two as being on the sacrum and being caused by pressure. It states that wound one had slight epithelialisation[15] and fragile surrounding skin, and no exudate[16] or odour. Wound one is recorded as being 2cm x 1.5cm with a depth of 0.5cm. The wound care plan states that wound two had slight granulation[17] and fragile surrounding skin, and no exudate or odour. Wound two is recorded as being 2.5cm x 3.5cm with a depth of 0.5cm.

42. It is documented on the wound care plan that over the following days Mrs A's wounds were cleaned and dressed at least daily by different nurses, using sodium chloride, Betadine,[18] Aquacel, Telfapad,[19] and Zetuvit,[20] and that there was "delayed healing".

43. RN H documented on the wound care plan that, on 15 Month2, the plan was "faxed to [NP K] for consult". RN H told HDC that RN G sent the fax, and she recalls seeing him do this. She then put the note on the care plan later that day, saying that it had been faxed.

44. RN H said that when she had not heard back from NP K after the fax had been sent, she telephoned NP K on 16 Month2, and left a message asking her to call back. There is a handwritten record in the rest home notes stating: "16 [Month2] call to [NP K] to come. No reply. Left msg. continue with current plan." NP K told HDC that as it was a Saturday, her telephone would have been switched off, with any calls going straight to voicemail. She stated that she does not recall receiving a voicemail message, and notes that there is no record that she returned a call on Monday 18 Month2.

45. RN H told HDC that she then scanned and emailed the care plan to NP K on 18 Month2. There is a further handwritten record in the rest home notes stating: "18 [Month2] scanned & emailed [care] plan to NP K." RN H also documented on the wound care plan: "[S]canned-emailed copy to [NP K] didn't get fax?" RN H and the rest home do not have a

[13] A low-adherent surgical dressing.
[14] A sterile dressing.
[15] A phase of wound healing.
[16] Liquid produced by the body in response to tissue damage.
[17] Granulation tissue is new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process.
[18] Antiseptic ointment.
[19] Non-adherent sterile dressing.
[20] Multi-layered absorbent dressing.

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copy of the email, and NP K told HDC that she does not have a record of it. NP K noted that she had had problems with her email in the past, whereby she had been sent referrals that she did not receive. She said that as soon as she became aware of this, she organised for the IT department to look into the matter, and the issue was fixed. NP K stated:

> "[I]t is fair to say that the people who did not receive a response from me in a timely way phoned to find out why, alerting me to the fact that I had not responded which doesn't appear to have occurred in this instance."

46. RN H stated that she did not hear back from NP K, but that in the meantime some improvement in the wound was noted, so she waited for NP K to contact her. From 18 to 22 Month2, it is documented in the wound care plan that the sacral wound was "slow healing".

47. Mrs A's heel wounds were added to the 14 Month2 wound care plan on 18 Month2. They were noted to be slow healing, and that the left heel had an open wound with no signs of infection, and the right heel had skin debrided from around the ankle area to expose the "necrotic[21] site", and that it was sore to the touch.

48. On 23 Month2, a new wound care plan was commenced for the sacral pressure area. The left heel wound is also noted. The front assessment page does not specify the size or condition of any of the wounds.

49. From 23 to 31 Month2, it is documented that the sacral wound was dressed at least daily by different nursing staff. The entries generally state that the wound was getting better, for example, "the wound is dry and healing better" and "wound looks better. No slough[22] noted".

Month3

50. On 1 Month3, the wound care plan states: "[W]ound looks worse, it was bleeding, surround[ing] skin looks intact but white [at] edges." On 2 Month3 it states: "[W]ound looks the same with white around margins but it is not bleeding." On 3 Month3 it states: "[H]ealing well."

51. On 4 Month3, Dr I conducted her monthly review of Mrs A. Dr I told HDC that RN H told her that, while she had been in contact with NP K on several occasions (by telephone and email) since 14 Month2, NP K had not physically reviewed the wound. Dr I said that on 4 Month3, a registered nurse reported to her that the sacral area had improved with the advice of NP K. Dr I noted from the rest home notes that the wound was "healing well but slowly". Dr I made the following notes of her review:

> "[D]oing well. RN reports that her sacral pressure sore is improving: in order to achieve this [Mrs A] is having to spend more time in bed so that she can be frequently turned and avoid pressure on that area (rather than sitting on a chair). She seems happy and content with this."

52. On 8 Month3, Dr J reviewed Mrs A regarding Mr A's concerns that Mrs A's toenails were thickened. Dr J recorded in the notes: "Staff report [Mrs A's husband] is concerned about

[21] Dead tissue.
[22] Dead tissue with a yellow or white appearance.

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her thickened toenails … O/E [on examination] clearly thickened nails likely secondary to fungus … Plan — no indication to treat, staff will keep clipped." Dr J told HDC that he does not recall whether rest home staff alerted him to any concerns in respect of Mrs A's pressure sores, and there is no indication from the rest home notes that Dr J was informed of any concerns about these.

53. On the evening of 9 Month3, nursing staff recorded that Mrs A had been "very sleepy throughout th[e] shift".

54. On 10 Month3, it was noted that Mrs A's right heel wound had almost healed, and that the necrotic area on the left heel was debrided. That evening, nursing staff noted that Mrs A was unwell, with rapid breathing, high blood pressure, high temperature, and high heart rate. Regular observations were taken approximately hourly from 8pm.

Admission to the public hospital

55. During the night, Mrs A's blood pressure dropped, and an ambulance was called to take her to the Emergency Department (ED) at the public hospital. She was assessed on arrival at about 4am on 11 Month3, and was noted to have a high temperature and low blood pressure. Mrs A was commenced on intravenous antibiotics and fluids to treat suspected sepsis.[23] Mrs A's serum creatinine level was 266µmol/L[24] on the morning of 11 Month3. It is documented that Mrs A's sacral ulcer was reviewed by the ED doctor and it was "not infective looking".

56. Infectious Diseases and General Medicine Physician Dr L was the clinician involved in Mrs A's acute care. He stated that the wounds on Mrs A's sacrum and heels were considered unlikely to be the explanation for her acute deterioration. Dr L noted that the clinicians involved in Mrs A's care did not consider it appropriate to transfer Mrs A to the Intensive Care Unit or the High Dependency Unit due to her co-morbidities. Accordingly, she was transferred to the General Medicine ward overnight.

57. Mrs A responded well to treatment, and by the morning of 12 Month3 she was afebrile,[25] her blood pressure was normal, her serum creatinine had markedly reduced to 114µmol/L, and a test for a urinary tract infection (UTI) had come back clear. Dr L said that he spoke with Mr A on the morning of 12 Month3, and Mr A agreed with the plan for Mrs A to complete her recovery at the rest home. Dr L stated that given that Mrs A was markedly better after 24 hours, and she was returning to a rest home environment, they did not see any reason for her to stay in the public hospital. Mrs A was discharged with a three-day course of Augmentin[26] and returned to the rest home via ambulance that afternoon. Mrs A had been catheterised during her hospital admission, and the catheter was removed on discharge.

[23] Illness caused by the body's response to infection.
[24] The typical reference range is about 45–90µmol/L for women. However, it was noted that Mrs A's baseline creatinine had been 100µmol/L on 3 March 2015. High levels of creatinine can indicate impaired kidney function.
[25] Without fever.
[26] Augmentin (amoxicillin) is an antibiotic used to treat a number of bacterial infections.

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Return to the rest home

58. Mrs A was noted to be settled on the days following her discharge to the rest home. On 13 Month3 it was documented that Mrs A's sacral wound was "slow healing, looking red and bleeding when cleaned".

59. Dr I reviewed Mrs A on 15 Month3. Dr I noted that during Mrs A's hospital admission no source had been found for the sepsis. Dr I told HDC that when she reviewed Mrs A she looked well but had some respiratory symptoms, "mainly wheezing, not really coughing". Dr I queried whether a lower respiratory tract infection was the cause of Mrs A's infection, and prescribed a further four days of Augmentin for Mrs A. Dr I stated that no concerns were reported regarding the sacral pressure sore at that time.

60. Over the following days, the entries in the wound care plan made by various staff generally note that the sacral wound was getting better.

61. On 25 Month3, Dr I reviewed Mrs A at the request of Mrs A's husband. Dr I recorded:

> "Asked to see patient as [her husband] was worried that she has been more sleepy than usual. Staff report that she has been quite unsettled at night recently: ?why more tired in day. Otherwise well in herself: no high temps, BP stable. Swelling of her legs stable. [S]taff report her sacral pressure sores and heels are slowly healing …"

62. Dr I told HDC that she asked rest home staff whether there were any signs of infection (of the sacral and heel pressure areas) and was advised that there were not. She stated: "As such I did not consider there was an indication or need to examine them at this time."

63. On 29 Month3, Dr J reviewed Mrs A. He recorded: "Asked to review by nurses — noted some discharge from right ear canal … Also check heel pressure sores … Both heels — skin breaking down, no infection." Dr J told HDC that he requested that the heel pressure sores be managed with pressure wound cares in accordance with the care plan. He stated that whilst no mention was made regarding Mrs A's sacral pressure sore, he had reviewed Dr I's notes of the consultation on 25 Month3, which noted that the sacral pressure sore was healing slowly.

Month4

64. On 1 Month4, the wound care plan for the sacral pressure area states both that the "wound [was] getting better surrounding skin fragile no signs of infection", and that the "wound [was] not healing surrounding skin starting to break down".

65. On 2 Month4, a further wound care plan was commenced for Mrs A's sacral wound, and it was noted to be a "continuation of [the] original care plan". The pressure area (in total) is noted to be 3x10cm with no depth recorded. The skin condition is listed as fragile, no odour is noted, and no other assessment is documented.

66. The wound care plan notes state on 2 Month4 that the wound was black in colour and the surrounding skin was fragile and flaky. On 6 Month4, the notes state that the wound margin was healing well, and that the wound area was looking better.

67. On 6 Month4, Mrs A had her monthly review with Dr J. He recorded:

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> "Only concerns staff have are management of her sacral and heel pressure areas. The sacral lesion is being kept damp by her incontinence, she has previously had unsuccessful catheterisation attempts … Plan — sores not examined today — suggest [RN H] as most experienced should try [catheterisation] again … continue 2 hourly turns and regular dressings."

68. Regarding this review, Dr J told HDC that nursing staff were concerned that urinary leakage was affecting the healing of the sacral pressure area, and attempts to catheterise Mrs A had been unsuccessful. Dr J told HDC that he requested that staff reinsert the catheter and continue pressure sore nursing cares. Dr J said that his plan was to discuss with Dr I the best way to have Mrs A catheterised, but the discussion did not take place because, on 9 Month4, Mrs A was catheterised successfully by RN H.

69. On 9 Month4, it was noted in the wound care plan both that Mrs A's "wound appear[ed] to be healing very slowly" and that the "wound site [was] not healing, no signs of infection".

70. On 11 Month4, it was noted that the wound size was increasing, the centre of the wound was oozy, and there was a high risk of infection. On 13 Month4, the notes document: "[W]ound dressing has been changed as per manager's instruction. Centre of wound bed necrotic."

71. On 16 Month4, Dr I was asked to review Mrs A as her sacral pressure sore had worsened over the last 24 hours. Dr I recorded:

> "[T]hey have managed to insert urethral catheter so that she can stay drier now. Over the last 24hrs her sacral pressure area has become much smellier and now seems to be developing a sinus. OE: large sacral pressure area — very offensive smell, non-tender. Imp: infected? Plan: for 1/52 augmentin — [RN H] referring to [NP K] (wound care specialist) for review."

72. Dr I stated that as the wound was large, she considered there to be a risk of it beginning to become infected or colonised. She therefore prescribed antibiotics, and said that she asked the rest home to contact NP K again urgently to review the sacral area and offer her expert opinion on how to treat and manage it.

73. There is no documentation to suggest that Mr A or his children were informed about Mrs A's condition at this time.

74. On 18 Month4, it is documented on the wound care plan by different nurses: "[W]ound looks the same appears to be healing slowly," and also, "[W]ound looks the same (really bad) looks deep, wound margin is red, wound is necrotic, offensive odour."

75. On 19 Month4, RN H emailed NP K to request a wound care consultation. The email included details of Mrs A's wound and explained that it had been present for the past three months. The email stated: "I was finally able to [catheterise] her two weeks ago which has made some slight difference. I would really appreciate your input and siting of this wound please." The referral did not include Mrs A's name, National Health Index (NHI) number or date of birth.

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76. On 20 Month4, Dr J reviewed Mrs A. He recorded: "Review sacral wound … O/E large deep ulcer, no clear cellulitis, necrotic tissue adherent to base of the wound. Plan — [RN H] will liaise with [NP K] and then discuss with me." Dr J told HDC that he recalls that Mrs A appeared clinically well during this consultation.

77. RN H told HDC that, on 21 Month4, she left work early as she was unwell. She stated that she handed over to the charge nurse, and asked him to follow up with NP K. RN H stated that the charge nurse contacted her saying that he could not get hold of NP K. Accordingly, RN H said that she contacted NP K herself, obtained advice, and called the charge nurse back, and a new wound care plan was commenced.

78. Regarding the wound care referral, NP K told HDC:

> "The Wound Care team only ever received one referral by email from [the rest home] and Rest Home Facility Manager [RN H] on 19 [Month4]. The referral related to [Mrs A's] sacral pressure ulcer that had been present for 3 months but which had recently worsened. I discussed the case with the Facility Manager by phone on Tuesday 21 [Month4] to assess the degree of the problem and advise on patient care until I could get out to [the town] to see [Mrs A]. [RN H] agreed to send me further information (NHI and Date of Birth) so that I could process the referral and schedule a visit. I did not receive any further information …"

79. A new wound care plan was commenced on 22 Month4, which noted the sacral wound as being 5 x 6cm and 3cm deep. There is a detailed one-page dressing plan that states how to clean and dress the wound. It states that it was discussed with NP K.

80. On 22 Month4, the progress notes state that Mrs A's eating and drinking had decreased, and that Mr A was concerned for his wife's health. Mrs A's observations were taken regularly overnight. Her temperature increased throughout this period.

81. On 23 Month4 at 7am, a nurse noted that Mrs A was drowsy and weak, and that her observations had been fluctuating. The nurse documented:

> "I rang [RN H] and as per her advice I rang [Dr J] at 8.00am and explained [Mrs A's] condition and inform that it's better to send her to hospital. He suggested that he will come and see her at 10.45 and then he will decide."

82. Dr J attended Mrs A and noted that she had been unwell since the previous night. On examination, he determined that clinically she was septic, and he arranged an immediate transfer to hospital in consultation with Mr A. Dr J's notes for his visit state:

> "Since last night — feverish, reduced conscious level, not eating or drinking. Background [history] — dementia, bed bound, large sacral pressure area, recent urinary catheterisation … [Impression] septic ? secondary to chest or UTI."

83. Mrs A was transferred ED by ambulance, arriving at 2pm. On review, she was noted to be drowsy with a high temperature, pulse, and respiratory rate. She was noted to be "not for resuscitation", "as per [the rest home] notes and family wishes". Her pressure ulcer was documented as being 6cm x 7cm and 6cm deep, with an area of necrotic skin in the ulcer,

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and offensive discharge. Mrs A was reviewed by the plastic surgery registrar, and the wound was dressed. At 5.40pm, Mrs A was seen by a medical registrar who told HDC:

> "When I was alerted about [Mrs A] in ED and saw her initially, she had just vomited. The ED nursing staff appropriately turned [Mrs A] to her side in an attempt to prevent aspiration (this is standard medical protocol) particularly so in [Mrs A's] case as she was gravely ill and at risk of compromising her airway. I asked [Mr A] ([Mrs A's] husband) and his son to kindly step out of the cubicle as I saw they were quite distressed (especially [Mr A]) at the sight of [Mrs A] becoming unwell. Instead of discussing her situation out in the open, as it would be compromising confidential information, I asked them to please follow me to the family room near ED so I could privately talk to them about [Mrs A's] grave prognosis in a quiet and confidential setting … When I returned to the cubicle in ED to see [Mrs A], she had unfortunately passed."

84. Sadly, Mrs A died in the ED at the public hospital. Her death certificate states the cause of death as: "Sepsis secondary to chest infection, Sacral ulcer — necrotic." It was also noted that Mrs A had been bedbound, and had had Alzheimer's dementia, hypertension, acute kidney injury, and poor mobility.

85. NP K stated that, as she did not receive any further information from RN H, she emailed her on 31 Month4 to find out how Mrs A's pressure ulcer was responding and how staff were doing with implementing the advice she had given, and to request Mrs A's NHI and date of birth. RN H responded that Mrs A had been admitted to the public hospital and that, very sadly, she had passed away.

Further information

Rest home wound care policy and form

86. At the time of these events, the rest home had a "Skin Management and Wound Care Policy" and associated "Wound Care Assessment and Management Plan" form, which were documents provided by another rest home organisation.[27] RN H told HDC that she had adapted the form to include supplementary detail.

87. The "Skin Management and Wound Care Policy" sets out that all new residents need to have any wounds photographed and an impression of the wound taken on admission, but there is no requirement for photographing of wounds that develop while in the rest home/hospital. The policy also specifies that residents are to have a Waterlow pressure area risk assessment six monthly. The policy states: "[U]se pressure reducing mattresses for those confined to bed, and most at risk," and, "[E]valuate wounds at each dressing change or at least once a week to ascertain if wound healing occurring and the need for further intervention or product change." In relation to skin tears, the policy gives details of dressing methods to be used for category one, two and three tears, and also states: "Rely on your own clinical judgement. This is a guide only."

[27] The rest home told HDC that it paid a fee to use these policies. In the most recent Ministry of Health audit (\it states that the rest home has a business relationship with the other rest home organisation and uses the policies and procedures to support good practice. RN H stated that they shared training days and meetings to discuss quality assurance and management practices.

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88. The "Wound Care Assessment and Management Plan" form, as used in Mrs A's case, has a covering sheet to identify the patient information and details of the wound (eg, type, tissue loss, wound location, measurement). It has space to record four different wounds. The subsequent pages have columns to record the date, wound number, dressing method, evaluation of wound, and outcome.

89. The Skin Management and Wound Care Policy and the Wound Care Assessment and Management Plan, including that used in Mrs A's case, did not require pressure wounds to be staged using a recognised classification system. These documents do not reference additional wound care resource materials for staff; however, RN H stated that there were two copies of the Prevention and Treatment of Pressure Ulcers Clinical Practice Guidelines onsite.

RN H

90. RN H worked at the rest home for nine years. She told HDC that it was never just a job for her, but it was a calling and a privilege to care for the elderly and their families in her own local community.

91. Initially, RN H was employed as a registered nurse. Two years later, she became the Nurse Manager and then, the Clinical Manager. In 2014, she entered into a new salary plan with the rest home owner, which acknowledged that she was undertaking the roles of registered nurse, and the "[n]ormal management role as well as that of clinical manager". RN H stated that she was on call 24 hours, seven days a week. Accordingly, she explained that it was common for her to insert notes into the clinical record on her return to the rest home premises.

92. RN H stated that she was kept informed by staff by frequently attending staff handovers in the mornings and afternoons. She said that she met with registered nurses before and after the GP visits, and that she would meet the GPs after they had finished their rounds to briefly discuss the outcomes requiring follow-up with the nurses. RN H said that she completed the rosters and managed all staff at the rest home, which was between 25 and 30 casual and full-time staff. RN H said that there were three main shifts (morning, afternoon, and night), and she balanced staffing ratios to ensure that in the mornings there was plenty of support for registered nurses from caregivers. She also said that in 2015 she rostered a team leader charge nurse to work from 9am to 5pm.

93. The Nurse Manager job description states that the Nurse Manager "[e]stablishes and co-ordinates a competent, compatible care team so that they achieve delivery of effective, professional and comprehensive nursing care in a residential setting". It also states that the Nurse Manager is responsible for ensuring effective nursing care; ensuring that household maintenance standards are met; meeting legislative obligations; safe administration of medicines; staff training; health and safety; and quality improvement.

94. The Clinical Manager job description states that the Clinical Manager has working relationships with the Directors, all staff members, visiting health professionals, and residents and their families. It states that the Clinical Manager "[e]stablishes and co-ordinates a competent, compatible care team so that they achieve delivery of effective, professional and comprehensive nursing care in a residential setting", and is responsible for ensuring effective nursing care and "develop[ing] and implement[ing] nursing care plans to

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deliver a comprehensive and consistent pattern of care". It also provides that the Clinical Manager is authorised to ensure that residents have access to appropriate medical care, is authorised to purchase medical supplies, and will promote safe practice among staff. The job description further states that the Clinical Manager "actively participates in and promotes the development and maintenance of a quality assurance programme … initiates, actively participates in, and promotes the clinical review process, and assists in the development of clinical policy".

95. RN H explained that she was the "fulcrum point of the natural tension between the owners' interests and their financial constraints, and maintaining nursing standards, as well as carrying the expectations of the community". RN H told HDC that the hourly pay rate that the rest home offered was significantly lower than DHB rates, and no New Zealand-trained nurses wanted to work full time at the rest home for that rate. She said that, as a consequence, in 2014–2015 the rest home employed a stream of foreign-trained nurses who sought work experience at the rest home until they could obtain DHB work. RN H explained that it was challenging to build up good communication between the registered nurses and the GPs because of the high staff turnover. RN H said that she provided stability and consistency by introducing a charge nurse role, and rostering the same charge nurse on the week day morning shifts so that the GPs would deal with the same nurse most of the time.

96. RN H told HDC:

> "On reflection, I could have been more assertive with the GP, [the public hospital] and Wound Care Specialist to make them take more responsibility for the wound care. An earlier referral with GPs and consultation with [NP K] and other Wound Care Specialists may have spurred a transfer of [Mrs A] to a more appropriate setting, but this would have been a move to facilities away from her [home] and family."

97. RN H said that there were no photographs taken of Mrs A's sacral wound, and that this certainly "would have made a difference when referring to Wound Care Specialists". RN H stated: "Clinical oversight of [p]ressure wound care was done by myself. I attempted to do this using the best evidence available to me and the care team at the time."

98. RN H submitted that Mrs A did not receive the appropriate wound care primarily because the wound care policy at the rest home did not provide for sufficient written assessment of the wounds to document and communicate adequately between all of those responsible for her care, and especially between those who administered the care for Mrs A and could see how bad her wounds were, and those who made the decisions about her treatment and care.

99. RN H submitted that there were numerous people and agencies responsible for Mrs A's ultimate care.[28]

100. RN H stated that by 12 Month3, she was very concerned about Mrs A's wound care, and she arranged with Dr I to have a meeting between the GPs, the manager of the medical centre, and the rest home owners, on 24 Month3, to improve communication.

[28] She lists Ministry of Health auditors, the DHB, the GPs, the owners of the rest home, herself, other registered nurses, caregivers, Mrs A's family, and Mrs A herself.

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Rest home owner

101. In response to RN H's statement that she was on call 24 hours, seven days a week, the director Mr M told HDC that the rest home provides 24/7 registered nurse cover, and explained that there were other resources available to nurses after hours (after-hours GP service at the medical centre, an after-hours service, a telephone health service, and an ambulance service). Mr M explained that RN H had the responsibility to support registered nurses, and in particular the new registered nurses, to enable them to work independently after some time. He said that this arrangement was not unusual for a nurse manager in a small facility such as the rest home. The rest home now has a new Facility Manager who told HDC: "[A]s a Facility Manager I expect to be on call 24/7, however it can be useful to empower staff to take responsibility for their decision making."

102. Mr M explained that high registered nurse turnover is a problem in many rural facilities in New Zealand, and that many overseas-trained staff will work for a short time in a small facility to gain the nursing experience required for a better job. Mr M stated that the rest home cannot compete with public hospital pay rates, and cannot provide systematic training as public hospitals do, and that the nursing staff turnover is still an issue.

103. Mr M said that he and his wife had a good relationship with RN H, and that they gave her authority to use money in the rest home bank account to go towards items for care, equipment, staff welfare, petrol, flowers, etc, unless it was a larger item that they could not afford. He said that RN H could transfer any amount of money from the account to pay for various things, so he cannot believe that she would not withdraw money from that account to cover staff training. Mr M said that RN H never told him that she had personally paid for staff training,[29] and stated that there were adequate funds in the account to cover staff training.

104. Mr M stated that usually he paid for staff training himself, when he received notice of training opportunities (eg, from the DHB). He said that he would email RN H to check whether she or other registered nurses could attend, and then submit registration forms and payment.

105. Mr M said that from 2007, RN H had a period of excellent performance for seven years. However, from early 2014, he and Mrs M noticed that RN H spent more time away from the facility. Mr M said that he and Mrs M visited the facility every Wednesday, and would meet with RN H regularly. He said that when they asked whether she was stressed or under pressure, she would say that there was no problem. Mr M said that repeatedly he told RN H that whenever she wanted days off, to tell them and they would go to the facility to cover some duties. He also noted that after RN H had completed big tasks (eg, an audit) they would offer her some time off. Emails detailing leave arrangements were provided to HDC.

106. Mr M stated that after two clinical managers had left, RN H told him that she did not want another clinical manager and would take on the role herself. Mr M said that he told RN H more than once that they could pay for an experienced registered nurse to be a clinical manager.

[29] The training RN H told HDC that she paid for is set out in the "subsequent events" section later in this report.

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107. Mr M stated that as a manager, RN H had the responsibility for resident and staff safety and well-being. He stated that as the directors and owners of the business, they did their best to support RN H in her management.

The DHB

108. NP K told HDC:

> "[The DHB's] Wound Care Team comprises 3 nurses. While it would be nice to think that the Specialist Wound Care team could review all wounds of patients in rest homes in the DHB within a few days of receipt of referral, it is neither practical nor necessary. Wound care is considered part of the usual practice of a Registered Nurse (RN), which means that the bulk of patients with wounds are managed by RNs without specialist advice …
>
> The expectation of the wound care team is to provide specialist advice for patients with wounds that have failed to respond to treatment. From the information on the referral [Mrs A] appeared to meet this criteria. In the case of pressure ulcers a phone call to assess the degree of urgency and advise interim care until a visit can be made is standard practice. Upon receipt of the information I was waiting for from the Facility Manager I would have scheduled a visit to review [Mrs A] on the first available day, which would have been 23 [Month4]. Unfortunately I did not receive the information and therefore was unable to visit on this day."

The family

109. Mr and Mrs A's children complained to HDC about the care Mrs A received from the rest home, Dr I and Dr J, and the public hospital in the last months of her life, particularly in relation to her sacral wound. Mr A told HDC that the first time he was aware of the sacral wound was when Mrs A was admitted to the public hospital on 11 Month3. Mr A queried why he was not told how unwell his wife was.

Medical centre

110. Dr I told HDC that in 2014, she had a family meeting with Mr A and two nurses from the rest home. Dr I stated that she explained to Mr A that Mrs A's overall health and mobility, in general, were gradually deteriorating, and that this was a longer-term process.

111. Dr I stated that on 24 Month3 2015, she met with RN H, rest home owner Mr M, and the medical centre practice manager. Dr I stated that the purpose of the meeting was to discuss some concerns that she and Dr J had about the care of some of the patients at the rest home, especially around communication and chronic wound management. Dr I stated that various suggestions for improvement were made, and they came up with ideas on how communication and histories could be improved at handover and when presenting to the doctors.

112. Dr J considers that on 6 Month4 he should have examined the sacral pressure area to satisfy himself that it was not infected. However, he did not check it because he was focused on the catheter insertion, and there was no indication by the nursing staff to review the wound.

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113. Dr I considers that, with the benefit of hindsight, it may have been appropriate to have examined the sacral wound on 14 Month2, but it is unlikely that this would have changed her management, and she would have still requested a referral to NP K.

114. The medical centre stated that pressure area management is a core nursing duty, and doctors rely on rest home staff to alert them to any patients who have high-risk pressure areas.

115. The medical centre stated:

> "We would like to again express our sincere condolences to [Mr A] and his family for their loss and for what, no doubt, has been an upsetting and distressing time. It was a pleasure and an honour to have been able to care for [Mrs A]."

Subsequent events

Changes made at the rest home

116. Following the family's complaint, RN H undertook a review together with DHB specialists (including NP K). This included review of the rest home wound care policies, guidelines, and assessment documentation. The review found that there were issues with the wound care assessment and management plan, and the skin management and wound care policy. In particular, it noted that there was not an objective method of documenting wound healing progress. The review was completed in January 2016 and resulted in an overhaul of the wound care documentation. The rest home now uses a new Skin Management and Wound Care Policy, and associated forms. The policy includes greater detail about the management of pressure areas, and refers to the Braden Scale[30] for pressure ulcer risk assessment. It also requires pressure ulcers to be staged against the National Pressure Ulcer Advisory Panel staging system.[31] The wound assessment form includes a specific wound re-assessment page, there is a more detailed wound care planning page, and the wound evaluation form provides for objective evaluation of a wound.

117. RN H stated that the following changes were implemented at the rest home while she was Nurse Manager/Clinical Manager:

- All registered nurses were given training in the appropriate use of the wound management manual.
- A wound care product representative became part of the on-site training programme, providing training and in-services for rest home staff.
- In-services were offered to all staff on effective communication and reporting.
- An online training programme was set up with Care Advisory Services for rest home staff to access an additional training tool.
- Three staff attended a wound care seminar in a main centre. RN H stated that the owners of the rest home agreed to fund only two staff to attend, so she funded one more personally.

[30] A tool developed to help health professionals assess a patient's risk of developing a pressure ulcer.
[31] The National Pressure Ulcer Advisory Panel (NPUAP) is an independent not-for-profit professional organisation dedicated to the prevention and management of pressure injuries.

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- Four staff attended a wound society seminar in another centre. RN H stated that the owners of the rest home did not agree to fund this, so RN H personally funded four staff attending.
- RN H met with the medical centre GPs to discuss the new wound care management protocols.
- It was arranged for a the DHB nurse practitioner to spend time with the rest home registered nurses during GP rounds to promote effective clinical communication.

118. RN H has not worked at the rest home since February 2016, and the rest home now has a new Facility Manager. The rest home told HDC that there have been a large number of staff resignations due to changes occurring at the rest home, and that currently there are no nurses working at the rest home who were involved in Mrs A's wound care.

119. Mr M stated that after the complaint was received, he met with Mrs A's family. Following this process, RN H also met with Mrs A's family.

Medical centre

120. The medical centre told HDC that it met with the rest home on multiple occasions in late 2015 and through 2016 to discuss service improvements. It stated that it now meets with the rest home management regularly. The medical centre advised that there is improved supervision of nurses at the rest home, and there is a key point of nursing contact at the medical centre for rest home nurses to contact during the day. The doctors attending the rest home now use a laptop to directly access all medical records relating to the patient while at the rest home.

Ministry of Health unannounced surveillance audit

121. In 2016, HealthCERT undertook an unannounced surveillance audit of the rest home. Twelve of 21 standards were only partially attained. One standard rated high risk, seven rated moderate risk, and four rated low risk. The high risk standard related to quality and risk management systems, and ensuring that health and safety management systems are fully implemented. The moderate risk standards related to the implementation of policies and procedures, internal audits, reporting of pressure injuries as adverse events, human resource management, education, timeframes for care planning, incomplete care plans, incomplete recording and monitoring of fluids, restraint interventions and monitoring, and infection control surveillance data.

122. As a result of the findings, an additional unannounced surveillance audit was imposed. This was undertaken in 2017. At that time, the rest home had 20 residents. The audit found that improvements continue to be required in relation to informed consent, business planning, implementation of the quality and risk management system, staff orientation, staff education, assessments, care plan interventions, monitoring, evaluations, food service, restraint, and infection surveillance. The audit identified the following additional areas requiring improvements: complaints management, reference checks, updating changes to support needs, and medication management.

123. The rest home owner's HealthCERT certificate will expire in early 2018.

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Cultural audit

124. The DHB requested a cultural audit of the rest home as a result of complaints made by Mrs A's family in relation to her care. The request stated: "We wish to ensure that the facility meets cultural safety requirements. We want the local population of [the town] to have confidence in their only aged care facility …"

125. The audit was completed in 2016, with the main recommendation being that the rest home co-design with the DHB's Maori Health Unit , a health service improvement plan. Other recommendations included collecting correct ethnicity data on admission, creating a cultural care plan, undertaking cultural safety training, developing a cultural activities plan, developing a community engagement plan, and encouraging staff to pursue further education and upskilling programmes.

Responses to provisional opinion

126. A response to the provisional opinion was received from the rest home's owner. Mr M told HDC that he considers that Dr I should have reviewed Mrs A's wounds herself rather than relying on accurate descriptions of the wound condition from nursing staff. Mr M also stated that he recalls RN H telling him that she felt frustrated at not being able to get hold of the wound care specialist, NP K.

127. RN H advised that she has accepted my provisional decision. The medical centre had no comments to provide in response to my provisional opinion. The DHB advised that it has accepted my recommendation. Mrs A's family provided a response to the "information gathered" section of the report, and their comments have been addressed in covering correspondence.

Opinion: Rest home owner — breach

Introduction

128. The rest home owner had a duty to provide Mrs A with services with reasonable care and skill. This includes responsibility for the actions of its staff, and an organisational duty to facilitate continuity of care such as ensuring that all staff work together and communicate effectively. It 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."

Wound care — breach

129. Mrs A was a hospital-level resident at the rest home. She was assessed early in her admission and again a few months later as having a very high risk of developing pressure areas. Blisters on Mrs A's heels and a skin tear on her sacrum were first noted in mid-Month1. Mrs A's sacral wound did not heal.

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130. At the time of these events, the rest home had a Skin Management and Wound Care Policy and associated Wound Care Assessment and Management Plan form to record details and evaluation of specific wounds. RN H told HDC that she had adapted the form to include supplementary detail. As outlined above, neither the policy nor the form (including that used in Mrs A's case) required pressure areas to be staged using a recognised classification system, and these documents do not reference additional wound care resource materials for staff. However, RN H stated that there were two copies of the Prevention and Treatment of Pressure Ulcers Clinical Practice Guidelines on site.

131. From the time that the blisters on Mrs A's heels and the skin tear on her sacrum were identified, five wound care plans were implemented in relation to the sacral wound. Some, but not all, of those plans also included the pressure sores on Mrs A's heels. Generally the sacral wounds were evaluated on a daily basis and the plan updated by various staff.

132. Mrs A's sacral wound was not described accurately in the wound care plans by multiple rest home staff, and often conflicting and subjective descriptions of the wound were recorded, over an almost three-month period. For example:

- The new wound care plan commenced on 14 Month2 showed that the sacral wound had approximately doubled in size since the first wound care plan for the sacral wound was commenced (17 Month1). However, subsequent evaluations generally noted that the sacral wound was healing and getting better.

- On 1 Month4, the wound care plan for the sacral wound states both "wound is getting better surrounding skin fragile no signs of infection" and "wound not healing surrounding skin starting to break down".

- On 9 Month4, it was noted in the wound care plan both that Mrs A's "wound appear[ed] to be healing very slowly" and that the "wound site [was] not healing, no signs of infection".

- On 18 Month4, it is documented on the wound care plan both "wound looks the same appears to be healing slowly", and "wound looks the same (really bad) looks deep, wound margin is red, wound is necrotic, offensive odour". These assessments followed Dr I's review on 16 Month4, which stated: "[S]acral pressure area has become much smellier and now seems to be developing a sinus."

133. My expert advisor, RN Jan Grant, advised:

> "The wound care [form] which is used to assess, document and evaluate the wound, lacks consistency and accurate assessment data. The assessments/evaluations appear to be very subjective in nature … Best practice would indicate that there is an International Pressure Ulcer Classification System which would have allowed the Hospital and Rest Home to accurately discuss and identify the wounds to other health professionals … It appears that staff advised that the wound was continuing to heal up until [Month4]. Wound Care notes and nursing Progress Notes demonstrate that this was not the case. I am of the opinion that if an internationally recognised Wound Care Assessment process for pressure areas had been used then staff would have had a more

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> objective tool to use rather than the subjective documentation that appears in the Wound [forms]."

134. I agree with RN Grant's advice. I am critical that the wound care policy and form did not guide staff to assess Mrs A's pressure areas objectively. I consider that this contributed to the ongoing failure on the part of rest home nursing staff to describe Mrs A's wounds objectively and accurately in wound care documentation.

135. In addition to this, I note that Mrs A's sacral wound was not viewed by a medical centre GP until 16 Month4, approximately three months after it was first identified, despite it having increased significantly in size, from two small wounds of 2cm x 1cm and 1cm x 1.5cm, to one large wound of 3cm x 10cm.

136. Dr I told HDC that when she reviewed Mrs A on 15 Month3, no concerns were noted regarding the sacral pressure sore at that time. Dr I said that on 25 Month3 she asked rest home staff whether there were any signs of infection of Mrs A's pressure areas, and was advised that there were not. Dr I documented: "[S]taff report her sacral pressure sores and heels are slowly healing."

137. On 29 Month3, Dr J reviewed Mrs A at the request of nursing staff in relation to her right ear canal. He said that no mention was made regarding Mrs A's sacral pressure sore, but that he had reviewed Dr I's notes, which noted that it was healing slowly. Dr J saw Mrs A again on 6 Month4. He did not review Mrs A's sacral wound but requested staff reinsert a catheter and continue pressure sore nursing cares. Dr J stated that there was no indication by the nursing staff to review the wound.

138. RN Grant advised:

> "Communication with [Mrs A's] GP [Dr I] appeared to lack accurate assessment and sound professional judgement in relation to wound healing … Documentation from 14 [Month2] showed that the wound had doubled in size and continued to deteriorate over the next couple of months. This information should have been conveyed to [Dr I]. … I am also of the opinion that if all information was given to the GP they would have been able to make sound accurate decisions and I also believe it is up to the nursing staff to pass that information to them."

139. RN Grant said that she did not consider the information provided was of an acceptable standard, and that this was a mild departure from acceptable standards. As already outlined above, RN Grant noted that staff appeared to have advised that the wound was continuing to heal up until Month4, which the wound care notes and progress notes demonstrate was not the case.

140. I accept RN Grant's advice, and I am concerned that full and accurate information about the status of Mrs A's sacral wound was not passed on by nursing staff to Drs I and J.

Conclusion

141. Overall, RN Grant considered that the wound care provided to Mrs A was not of an acceptable standard, and that this would be viewed by her peers as a moderate to severe departure from acceptable standards. I accept this advice.

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142. In my view, the rest home owner had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code. I consider that the following deficiencies are apparent in the care Mrs A received from the rest home owner:

- The descriptions of her sacral wound in the wound care plans, made by various staff, were inaccurate and inconsistent over a period of approximately three months;
- The wound care policy and form that were used did not guide staff to assess wounds objectively, and were inadequate. This contributed to inaccurate and inconsistent wound descriptions by staff; and,
- Rest home staff did not provide the GPs with full and accurate information to enable them to make sound, accurate decisions.

143. Overall, I do not consider that the care provided to Mrs A by the rest home owner was adequate. Accordingly, I find that the rest home owner did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Management — adverse comment

144. From 2014, RN H held both the roles of Nurse Manager and Clinical Manager at the rest home, as well as working as a registered nurse. She stated that she was on call 24 hours, seven days a week, and explained that she was the "fulcrum point of the natural tension between the owners' interests and their financial constraints, and maintaining nursing standards, as well as carrying the expectations of the community". RN H said that she completed the rosters and managed 25 to 30 staff at the rest home. She said that she balanced staffing ratios to ensure there was plenty of support for registered nurses in the mornings from caregivers. She also said that she rostered a team leader charge nurse to work from 9am to 5pm. RN H liaised with NP K on 21 Month4 regarding Mrs A's wound care, despite having already left work as she was unwell.

145. My expert advisor, RN Jan Grant, stated:

> "It is very difficult for a nurse manager to be on call 24/7, and to ring in and follow up staff/patient needs when off sick. [RN H], in my opinion, worked excessively and did not have adequate time off. Professionally, this is inappropriate and unsafe to have occurred."

146. Mr M stated in response that there were other resources available to nurses after hours. Mr M said that he and Mrs M met with RN H regularly to ask whether she was stressed or under pressure, and that she would say that there was no problem. He also said that repeatedly he told RN H that whenever she wanted days off, to tell them and they would go to the facility to cover some duties, and that after big tasks (eg, an audit) RN H would be offered some time off. Mr M also stated that after two clinical managers had left, RN H said that she did not want another clinical manager and would take on the role herself. Mr M said that he told RN H more than once that they could pay for an experienced registered nurse to be a clinical manager.

147. Mr M and Mrs M had a responsibility as employers and owners of the facility to ensure that RN H was supported appropriately to manage the rest home. Despite any reassurances given

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by RN H, I consider that Mr and Mrs M could have taken further steps to ensure that the size of RN H's role was manageable and sustainable.

148. Mr M also told HDC that the rest home cannot provide systematic training for its staff. I am concerned at this statement. In my view, systematic training is especially important because the rest home is so reliant on overseas-trained staff who are unfamiliar with the New Zealand working environment, and there is regular change in personnel.

Communication with family — adverse comment

149. Mr A told HDC that the first time he was aware of Mrs A's sacral wound was when she was admitted to the public hospital on 11 Month3. Mr A was listed in the admission documentation as Mrs A's next of kin. There is nothing in the clinical records to suggest that Mr A was kept informed about his wife's sacral pressure area.

150. RN Grant advised:

> "Communication with family plays a vital role in ensuring that Family/[next of kin]/Whānau are informed of the issues when loved ones are in Residential Care … I am of the opinion that it is unacceptable not to communicate and keep family informed. I am of the opinion that communication was severely lacking and that [Mr A] was not informed of his wife's condition."

151. I accept RN Grant's's advice. There were multiple rest home staff involved in the evaluation and treatment of Mrs A's sacral pressure area. I consider that communication of Mrs A's condition to Mr A was the responsibility of all nursing staff involved in caring for Mrs A, and I am critical that this did not occur.

Opinion: RN H — breach

Introduction

152. RN H was the Clinical Manager and Nurse Manager, and also undertook registered nurse duties at the rest home at the time Mrs A was a hospital-level resident. Both the Nurse Manager and Clinical Manager job descriptions state that the manager is responsible for ensuring effective nursing care.

153. As the Clinical and Nurse Manager, RN H had responsibility for clinical oversight of Mrs A's pressure wound care, including the care provided by other nursing staff. In her role as Clinical Manager she had a working relationship with visiting health professionals, which included the GPs.

154. I acknowledge RN H's concerns about the hours she worked, the size of her role, and her statement that she was the "fulcrum point of the natural tension between the owners' interests and their financial constraints, and maintaining nursing standards, as well as carrying the expectations of the community". However, this did not excuse her from her professional responsibilities. In my view, RN H did not fulfil her responsibility to ensure that effective nursing care was provided to Mrs A.

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Clinical oversight and wound care

155. RN H said that she was kept informed by nursing staff by frequently attending staff handovers in the mornings and afternoons. She said that she met with the nursing staff before and after the GP visits, and that she would meet with the GPs after they had finished their rounds to briefly discuss outcomes requiring follow-up. RN H told HDC that she provided clinical oversight of pressure wound care, and attempted to do this using the best evidence available to her and the care team at the time.

156. In this case, RN H was also directly involved in Mrs A's wound care management. This is reflected in the wound care plans and the contact that RN H had with the GPs on various occasions, including being asked to make urgent referrals to NP K twice, the first of which was after Dr I's review on 14 Month2, when Dr I noted that she had been informed that Mrs A's sacral area was not healing.

157. RN H said that she telephoned NP K on 14 Month2 regarding Mrs A's sacral pressure area. RN H made notes of the telephone call setting out advice including to catheterise Mrs A if her pads could not be changed regularly, and to use Cuticerin if there were areas of necrosis. NP K does not recall this telephone call, and said that she is surprised that she would make those recommendations.

158. A short-term nursing care plan was commenced on 14 Month2, and a new wound care plan was also commenced that day. RN H documented that the care plan was faxed to NP K for consultation. RN H said that when she did not hear back from NP K, she left a follow-up voice message on 16 Month2 and documented: "[C]all to [NP K] to come." NP K does not recall receiving this voice message.

159. RN H said that she then scanned and emailed the plan to NP K on 18 Month2, and documented that she had done this. HDC has been unable to obtain a copy of the email. NP K said that in the past she had had problems with her email, whereby she had been sent referrals that she did not receive, but that the issue had been fixed. She said: "[I]t is fair to say that the people who did not receive a response from me in a timely way phoned to find out why." RN H stated that she did not hear back from NP K, but that in the meantime some improvement in the wound was noted so she waited for NP K to contact her.

160. RN H then sent an email referral to NP K two months later, on 19 Month4, with details of Mrs A's wounds, but RN H did not include Mrs A's details (name, NHI, date of birth). This referral was made three days after Dr I requested NP K be contacted again urgently because Dr I had reviewed Mrs A and noted that her wound was large, smelt offensive, and was at risk of becoming infected. NP K said that the email of 19 Month4 was the only referral received from RN H. NP K then telephoned RN H on 21 Month4 to give advice until she could visit Mrs A at the rest home. NP K said that RN H agreed to send her Mrs A's NHI and date of birth so that the referral could be processed; however, NP K did not receive this information.

161. I acknowledge that there are different recollections in relation to whether RN H had telephone, fax and email contact with NP K for advice between 14 and 18 Month2. However, I note that RN H acknowledged that she did not hear back from NP K after 18 Month2. In addition, there was a delay of three days in making the urgent referral requested

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by Dr I on 16 Month4, and a subsequent failure to provide the NHI and date of birth to NP K so that the referral could be processed.

162. My expert advisor, RN Jan Grant, advised: "I believe a formal referral and a visit [from NP K] much earlier on would have benefited [Mrs A] and the staff at [the rest home]." I agree. I consider that, regardless of whether contact was made between 14 and 18 Month2, RN H should have done more to advocate for Mrs A's condition and follow up with NP K for advice.

163. In terms of communication with the GPs, as above, RN Grant advised:

> "Communication with [Mrs A's] GP [Dr I] appeared to lack accurate assessment and sound professional judgement in relation to wound healing … I am also of the opinion that if all information was given to the GP they would have been able to make sound accurate decisions and I also believe it is up to the nursing staff to pass that information to them."

164. RN H told HDC:

> "On reflection, I could have been more assertive with the GP, [the public hospital] and Wound Care Specialist to make them take more responsibility for the wound care. An earlier referral with GPs and consultation with [NP K] and other Wound Care Specialists may have spurred a transfer of [Mrs A] to a more appropriate setting, but this would have been a move to facilities away from [her home and family]."

165. I agree with RN Grant's advice. I also consider that, as the Clinical and Nurse Manager, with clinical oversight of Mrs A's pressure wound care and regular contact with the visiting GPs, RN H should have done more to advocate for Mrs A by ensuring that Mrs A's condition was communicated accurately to Dr I or Dr J, and that the wounds were reviewed by them. In my view, RN H failed in her responsibility as Clinical and Nurse Manager to escalate Mrs A's care adequately and coordinate with other services to ensure that Mrs A received the appropriate care.

166. Overall, RN Grant considered that the wound care provided to Mrs A was not of an acceptable standard, and that this would be viewed by her peers as a moderate to severe departure from acceptable standards. I agree. While I do not consider that RN H was solely responsible for the wound care that was provided to Mrs A, as the Clinical and Nurse Manager she was responsible for the clinical oversight of other staff, and for ensuring effective nursing care. In my view, RN H should have done more to advocate for Mrs A and ensure that she received appropriate wound care, and I am concerned that RN H did not do so.

167. In all of the circumstances, I do not consider that RN H provided care to Mrs A with appropriate care and skill and, accordingly, breached Right 4(1) of the Code.

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Opinion: Medical centre — other comment

168. The medical centre allocated a GP to the rest home to be the main person responsible for the medical care of its residents. Dr I was the GP regularly attending the rest home until Month3, at which time Dr J took over in this capacity.

169. On 14 Month2, Dr I conducted Mrs A's monthly review. Dr I said that she was told that Mrs A's sacral pressure area was not improving, and requested an urgent referral be made to NP K. Dr I said that she did not examine the sacral area as it was going to be reviewed by NP K. Dr I recorded that nursing staff were changing Mrs A's pads every three hours and regularly changing her position.

170. Dr I told HDC that, with the benefit of hindsight, it may have been appropriate to have examined the sacral wound on 14 Month2, but it is unlikely that this would have changed her management, and she would have still requested a referral to NP K.

171. On 6 Month4, Dr J conducted Mrs A's monthly review. Dr J told HDC that nursing staff were concerned that urinary leakage was affecting the healing of the sacral pressure area, and attempts to catheterise Mrs A had been unsuccessful. He recommended continuing regular turns and dressings, and for RN H to try catheterisation again.

172. Dr J told HDC that he considers that on 6 Month4 he should have examined the sacral pressure area to satisfy himself that it was not infected. However, he said that he did not check it because he was focused on the catheter insertion, and there was no indication by the nursing staff to review the wound.

173. My in-house clinical advisor, general practitioner Dr David Maplesden, advised:

> "There were two occasions when, with the benefit of hindsight, clinician review of [Mrs A's] sacral wound might have been indicated. These were 14 [Month2] ([Dr I]) and 6 [Month4] ([Dr J]). However, on 14 [Month2] documented nursing concerns related to recent lack of progress in healing of the wound with no signs of infection (rather than any significant deterioration) … [Dr I] gave appropriate advice, quite reasonably expecting that a [wound care specialist] would be examining the wound in the near future … With respect to [Dr J's] consultation, there is no indication he was asked by nursing staff to specifically review the wound … contemporaneous wound care notes suggest the wound was actually improving somewhat at this particular time (after a period of slow healing) with no signs of infection. Under the circumstances, I would not regard the failure by either doctor to physically review [Mrs A's] sacral wound on these occasions to represent a significant departure from expected standards, nor do I feel that her management plan is likely to have altered on these occasion even had the wound been reviewed
>
> I am satisfied that [Mrs A's] overall management by her GPs was appropriate to the information provided to them by [rest home] staff and management and to their observations of [Mrs A] on the occasions she was reviewed."

174. I accept Dr Maplesden's advice. With the benefit of hindsight, I consider that it might have been appropriate for Dr I to have reviewed Mrs A's sacral wound on 14 Month2, and for Dr

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J to have reviewed it on 6 Month4. However, I accept that based on the information available to the GPs at the time of their reviews, it was acceptable that they did not physically review Mrs A's sacral wound.

Opinion: DHB — other comment

Specialist wound care team

175. NP K told HDC that the expectation of the DHB wound care team is to provide specialist advice for patients with wounds that have failed to respond to treatment. NP K advised that in the case of pressure ulcers, a telephone call to assess the degree of urgency and advise interim care until a visit can be made is standard practice.

176. RN H said that she telephoned NP K on 14 Month2 regarding Mrs A's sacral pressure area. RN H made notes of the telephone call setting out advice including to catheterise Mrs A if her pads could not be changed regularly, and to use Cuticerin if there were areas of necrosis. NP K does not recall this telephone call, and said that she is surprised that she would make those recommendations.

177. A short-term nursing care plan was commenced on 14 Month2, and a new wound care plan was also commenced that day. RN H documented that the care plan was faxed to NP K for consultation. RN H said that when she did not hear back, she left a follow-up voice message for NP K on 16 Month2 and documented: "[C]all to [NP K] to come." NP K does not recall receiving this voice message.

178. RN H said that she then scanned and emailed the plan to NP K on 18 Month2. HDC has been unable to obtain a copy of the email. NP K said that she had had problems with her email in the past, whereby she had been sent referrals that she did not receive, but that the issue had been fixed. She said: "[I]t is fair to say that the people who did not receive a response from me in a timely way phoned to find out why." RN H stated that she did not hear back from NP K, but that in the meantime some improvement in the wound was noted, so she waited for NP K to contact her.

179. RN H then sent an email referral to NP K two months later, on 19 Month4, with details of Mrs A's wounds, but did not include Mrs A's details (name, NHI, date of birth). NP K said that the email of 19 Month4 was the only referral received from RN H. NP K then telephoned RN H on 21 Month4 to give advice until she could visit Mrs A at the rest home. NP K said that RN H agreed to send her Mrs A's NHI and date of birth so that the referral could be processed; however, NP K did not receive this information.

180. I acknowledge that there are different recollections in relation to the contact between RN H and NP K. As a result, I cannot make any clear findings that NP K received any of the correspondence that RN H recorded having sent between 14 Month2 and 18 Month2. However, I am concerned about the uncertainty in relation to what was communicated between RN H and NP K, and consider that steps should be taken to avoid this happening in the future.

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Cultural audit

181. The DHB requested a cultural audit of the rest home by the DHB's Maori Health Unit . The request stated: "We wish to ensure that the facility meets cultural safety requirements. We want the local population of [the town] to have confidence in their only aged care facility …" Among other things, the audit recommended that the rest home and [the external organisation] co-design ahealth service improvement plan.

182. I commend the work undertaken. In my view, this work will help to ensure that the rest home is well equipped to service the cultural needs of its community.

Recommendations

183. I recommend that the rest home owner:

a) Arrange a wound care training session for the rest home nursing staff, given the number of new staff working at the rest home. This should specifically cover the management of pressure areas, and the use of the new wound care policy and associated forms. Evidence should be provided to HDC within three months of the date of this report that this has occurred or has been scheduled.

b) Arrange training sessions for the rest home nursing staff on:

i. Effective communication with family members;

ii. Clinical documentation skills; and

iii. Effective communication with GPs and other clinical personnel.

Evidence should be provided to HDC within three months of the date of this report that this training has occurred or has been scheduled.

184. I recommend that the rest home owner and the DHB work together to agree on a standard process for requesting advice from the DHB's specialist wound care team (the method of making the request and the information required in the request should be specified). Feedback on the process that has been agreed should be provided to HDC within three months of the date of this report.

185. In the provisional opinion, I recommended that the rest home owner provide a written apology to Mr A and his family for the failures identified in this report. This recommendation has now been met.

186. In the provisional opinion, I recommended that RN H provide a written apology to Mr A and his family for the failures identified in this report. This recommendation has now been met.

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Follow-up actions

187. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN H's name in covering correspondence.

188. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Ministry of Health (HealthCERT) and HQSC, 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 RN Jan Grant:

"I have been asked to provide an opinion on the care provided to [Mrs A] by the staff at [the rest home].

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 30 years' experience in Aged and Community care. I have had a variety of roles. I have represented NZNO and the Aged Care sector on a number of national working parties. I was 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 present role is as clinical advisor/rehabilitation coordinator in the community. I am a designated assessor for ACC.

I have been asked to review the documentation presented and answer the following questions:

1. Do you believe [Mrs A]`s sacral pressure area was managed in a timely manner consistent with expected standards by nursing staff? Was there any indication to refer to [the public hospital] sooner?

A review of all clinical notes was undertaken. This included nursing Progress Notes, Medical Notes, Wound Care Assessment and Management Plan and any other supporting documentation relating to wound care.

Entries in the Progress Notes in relation to wounds start from the 20.6.14

'*small laceration on R buttocks*'

The Progress Notes show entries which relate to wound care. Most of the entries are brief and state that wound care had been completed as per Wound Care Chart.

Entries showed that staff identified swelling of legs, skin conditions and other events that have affected care provided.

Wound Care Charts are presented as an on-going assessment of a wound. The front sheet of each Wound Care Chart has the patient's identifying information, also included is the wound type, tissue loss, wound location, measurements of wound and areas for staff to note the wound description. The form allows for four different wounds to be documented on the front of this form.

Subsequent pages are the progress of the wound and the dressing used to treat the wound.

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Forms which were included in the documentation provided, start from [late 2014] with a wound on [Mrs A's] inner thigh. This was listed with the dressing used and showed that the wound healed [several weeks later].

Another Wound Chart was commenced on the 17 [Month1] listing the wound as a pressure sore on the right and left side of the sacrum. The wound description was listed as 'skin tear only (pressure sore)'. It stated the surrounding skin is intact and there is no wound odour. It listed wound one on the left side of the sacrum as being 2cm by 1cm and wound two, the right side of the sacrum as being 1cm by 1.5 cm in size.

The dressing, treatment and evaluation of these wounds is, on average, daily. On the 20 [Month1] the Wound Chart stated 'the surrounding skin is fragile'. Several days later, the wound is described as red in colour but no sign of infection. From the 17 [Month1] till 14 [Month2] the outcome is listed as 'slow healing'. At this time staff noted no sign of infection.

On 14 [Month2] a new Wound Care Chart was commenced. It lists wound one and two as being on the sacrum and being caused by pressure. The assessment front page describes wound one, which is the left side, is listed as epithelialisation (pink) with surrounding skin as fragile, the depth is .5cm and the wound showed no exudate or odour. The size of the wound had been measured and had increased from 4 weeks ago.

Wound two which is the right side of the sacrum is listed as granulation tissue (red), no exudate or odour and .5 cm in wound depth. The size of this wound is listed as 2.5cm x 3.5 cm, an increase of double from 4 weeks ago.

Evaluations and dressings used were listed and it appears the wound is dressed on average, daily. From the 16 [Month2] the wounds are showing some ooze but no signs of infection.

On 18 [Month2] the wound looks slightly red and sore. 20 [Month2] and 22 [Month2] — No signs of infection.

A new Wound Chart was commenced on the 23 [Month2] and only listed pressure sores as one and two. There is no assessment of any other wound as per description list on the front of the Wound Assessment and Management plan.

Entries are daily and generally state the wound is getting better. On 25 [Month2] 'the wound is dry and healing better'. The 31 [Month2] 'wound looks better no slough noted'

1 [Month3] 'wound looks worse it was bleeding, surrounding skin looks intact but white edges'

4 [Month3] 'the wound margins are getting closer and good sign of epithelialisation, no sign of infection the wound is healing better'

13 [Month3] 'slow healing, looking red and bleeding when its cleaned was admitted to [the DHB] 11 [Month3]'

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18 [Month3] ‘wound looks better no sign of infection’

26 [Month3] ‘wound looking clean and intact healing well’

1 [Month4] ‘wound is getting better surrounding skin fragile no signs of infection’

1 [Month4] (PM) wound not healing surrounding skin starting to break down’

On 2 [Month4] a new Wound Chart documented ‘wounds now listed as 3cmx10cm’ no depth was listed and surrounding skin condition is listed as fragile. No wound odour and no other assessment is documented.

The continuation of dressing notes stated that

2 [Month4] ‘wound is black in colour, no odour but surrounding skin is fragile and flaky’

6 [Month4] ‘the wound area looking better and the surrounding skin getting better no other problems’

7 [Month4] ‘the wound getting bigger as the surrounding skin starting to break down, the wound bed is red and a bit sloughy’

9 [Month4] ‘the wound appears to be healing very slowly’

9 [Month4] ‘wound site not healing, no signs of infection, new skin abrasion R side groin area’

11 [Month4] ‘wound size increasing centre of wound sloughy and ooze high risk of infection’

12 [Month4] ‘wound area beginning to get sloughy wound edges breaking down some areas of healthy granulation’

13 [Month4] ‘wound dressing has been changed as per manager’s instructions. Centre of wound bed necrotic, outer edges of wound red, open and sore to clean’

16 [Month4] ‘wound dressing has changed. Centre site of wound is necrotic the wound edges red in colour healing slowly AB — augmentin 1/52’

17 [Month4] ‘wound necrotic in the centre odour++ wound looks very deep, debridement? Wound edges red and granulating’

18 [Month4] ‘wound colour the same appears to be healing slowly’

18 [Month4] ‘wound looks the same (really bad) looks deep wound margin is red, wound is necrotic, offensive odour’

18 [Month4] ‘wound oozing++ large cavity’

22 [Month4] ‘phoned [NP K] this morning to seek consultation regarding this’

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New Wound Chart on the 22 [Month4] lists the wound as 5cm x 6cm depth 3cm wound odour — Yes

The Dressing Plan states how to clean the wound. There is a one-page list of instructions that lists that this was discussed with [NP K]. The instructions state that [Mrs A] needed to be laid flat most of the time if she gets chesty, sit her up for short periods. She is not to go into the tub chair from now on. To be sat upright in chair at least for meals. Please give pain killers before making her sit up for the meals.

The Progress Notes also identify wound care but are more general in nature.

9 [Month2] 'Wound healing better'

On the 11 [Month2] the nursing notes 'Call to [NP K] wound care nurse for consult — no reply'

16 [Month2] 'all cares done Dx done on sacrum wound is still oozing and delayed healing'

24 [Month2] 'dressing done on sacrum slow healing no concerns voiced'

10 [Month3] Notes show that [Mrs A] was unwell and was admitted to [the public hospital] on 11 [Month3].

Her discharge summary from [the public hospital] on 12 [Month3] listed her Primary Diagnoses as Sepsis and Acute Kidney injury.

17 [Month3] 'Dressing changed on sacrum — healing well'

4 [Month4] 'Dressing changed on both heels wounds getting worse. Note both wounds have an odour'

A blank page included in the Clinical Notes is hand written and included dates.

On the 14 [Month2] ph to [NP K] re consultation re sacral pressure. It stated, 'try to catheterise if not change pads regularly. If necrotic area use cutecerin, AB if wound looks infected, lay as flat as possible keep off sacral pressure, no need for air mattress'

Another date 16 [Month2] Call to [NP K] to come no reply — left message, continue with current plan

18 [Month2] Scanned and emailed C/plan to [NP K]

10 [Month3] increase and decrease in BP and temp

11 [Month3] admitted to [the DHB] at 1am see DHB notes state, IV ABs and discharge x 3 Augmentin

15 [Month3] 1/52 Augmentin? LRTI source of infection

9 [Month4] Catheterised by manager 12g drained 1900mils

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16 [Month4] 1/52 Augmentin

22 [Month4] 11.30 called [NP K]

Summary of management of sacral pressure area

Issues in relation to care and management of sacral pressure area

The Wound Chart, which is used to assess, document and evaluate the wound, lacks consistency and accurate assessment data. The assessments/evaluations appear to be very subjective in nature. This is evidenced by the inconsistency of the notes in the Dressing Plan. E.g. the new Wound Chart on 14 [Month2] showed that the wound had doubled in size and subsequent evaluations stated that the wound was looking clean and intact and healing well (26 [Month3]).

Wound Charts do not accurately describe the wound and do not reflect any recognised National Identification as per Pressure Ulcer stages/Categories as documented in the evaluation of the Dressing Plan. (Information can be obtained from New Zealand Wound Care Society, The National Pressure Ulcer Advisory Panel NPUAP. Smith and Nephew.)

No photos were taken to monitor progress of the sacral wound. These can be useful when referring to other medical staff.

The wound description was not identified. Best practice would indicate that there is an International Pressure Ulcer Classification System which would have allowed the Hospital and Rest Home to accurately discuss and identify the wounds to other health professionals. This would also give staff who are attending to the wound an accurate assessment and treatment plan.

No evidence of resource material which is readily available in New Zealand. Published in 2014 — The Prevention and Treatment of Pressure Ulcers Clinical Practice Guidelines.

It is my opinion that the wound should have been viewed by the GP on or around the 14 [Month2]. The reason being that the wound had doubled in size within the last four weeks, and was not improving as stated in the on-going evaluation.

The GP was advised as this is evidenced in her documented notes on the 28/4/15 ‘Has sacral pressure sores (not examined) and is being made worse by urinary incontinence making area constantly wet. X2 RNs have tried to catheterise with no success.’ […]

An accurate assessment process based on recognised national guidelines I believe would have shown that the wound was not healing and was deteriorating over the 4 months.

I am of the opinion that the wound care provided to [Mrs A] was not to an acceptable standard. I am also of the opinion that this would be viewed by my peers as a moderate–severe departure from acceptable standards. The reason for this is that there

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is ample and easily accessible clinical information available for all facilities to ensure that best practice is followed.

2. Please comment on the quality of the information relayed to [NP K] and the GPs, by the nursing staff in relation to [Mrs A's] pressure wounds

It appears that the first time the GP [Dr I] heard about the pressure area was the 23 [Month1] when it was reported that [Mrs A's] sacral area was looking at risk of developing a pressure area so a decision was made to insert an IDC to prevent dampness in the sacral area.

[Dr I] stated in her letter (dated the 24 September 2015) that she did examine [Mrs A's] heels. The RN had advised her that the sacral pressure sore was very small and that the Doctor did not need to examine it. It is noted in the Dressing Plan that the wound was described on the 24 [Month1] as 'the wound was getting worse no slough but still fresh bleeding is evident. The skin is fragile and prone to break down'.

This documented evaluation of the wound is not consistent with what was told to the GP. The evaluation in the Wound Chart would indicate that the wound was stage 2 Pressure Area (partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed without slough).

On 14 [Month2] [Dr I] reported that she visited [Mrs A] as a routine monthly review. She stated that the RN reported that her heels were healing well but her sacral pressure was not improving. The RN reported that [Mrs A] was often trying to remove the dressing on the sacral area and scratching the area. There is nothing in the Clinical Notes to indicate this was a common occurrence.

At this time the GP requested an urgent referral to [NP K], the Chronic Wound Care Specialist at [the public hospital]. [Dr I] stated in her letter that [RN H] (the manager) agreed to do this. [Dr I] did not examine the wound at this time.

In [RN H]'s letter to the Commissioner received 28 September 2015, she stated that she made a telephone call to [NP K] and faxed the Care Plan to her on the 15 [Month2] and followed up with a scan and email on the 18 [Month2]. There is also an entry on the side of the nursing Progress Notes to say the 'faxed Wound Care plan to [NP K]'.

In a letter to the commissioner from [the public hospital] they stated that only one referral was received from [the rest home] which was on the 19 [Month4].

[Dr I] assumed that advice had been given on the wound management as she stated on the 4th [Month3], the RN reported that the sacral pressure area had improved with the advice from [NP K]. On the 8th [Month3], no concerns were noted about the pressure area. [Dr I] again reviewed on the 15 [Month3] following her return from [the public hospital], again no concerns regarding the pressure area. The Dr continued to manage [Mrs A's] medical issues. On the 25 [Month3] [Dr I] stated that she was informed that heels and sacral pressure areas were continuing to heal, albeit slowly, staff reported there were no signs of infection and she did not examine any wounds.

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The Wound Notes indicate that the first time [Dr I] examined the sacral pressure area was on the 16 [Month4], when she states she found a large sacral pressure that had an offensive smell. She started [Mrs A] on oral Augmentin. At this time, she asked for an urgent referral to [NP K].

Summary

Communication with [Mrs A's] GP [Dr I] appeared to lack accurate assessment and sound professional judgement in relation to wound healing.

Documentation from 14 [Month2] showed that the wound had doubled in size and continued to deteriorate over the next couple of months. This information should have been conveyed to [Dr I] and she should have viewed the wound.

It appears that staff advised that the wound was continuing to heal up until [Month4]. Wound Care notes and nursing Progress Notes demonstrate that this was not the case. I am of the opinion that if an internationally recognised Wound Care Assessment process for pressure areas had been used then staff would have had a more objective tool to use rather than the subjective documentation that appears in the Wound Charts.

I am also of the opinion that if all information was given to the GP they would have been able to make sound accurate decisions and I also believe it is up to the nursing staff to pass that information to them.

I do not believe that the information given to [Dr I] was of an acceptable standard. I am of the opinion that this departure from acceptable standards would be viewed as mild from my peers.

3. Was it appropriate for [NP K] to verbally give advice over the phone on 21 [Month4]? Do you believe a physical examination was warranted?

Documentation from [NP K] showed that she received an email on the 19th [Month4]. The email started off by saying that the facility has a resident that has a necrotic sacral pressure. The email describes what dressings were done. The email also outlines the medical history of [Mrs A].

Documentation presented by [the rest home] shows a one-page list of instructions that lists the issues that were discussed with [NP K]. The instructions state that [Mrs A] needs to be laid flat most of the time if she gets chesty, sit her up for short periods. She is not to go into the tub chair from now on, to be sat upright in chair at least for meals. Please give pain killers before making her sit up for the meals.

In the event of [NP K] not being able to get to the facility, then verbal advice over the phone, I believe, is acceptable for a short period of time. [NP K] had asked for an NHI and DOB to indicate a formal request and then would have arranged a visit. None of the parties asked nor offered to see a photo of the wound which could have assisted [NP K] in giving clinical advice based on evidence she would have viewed.

I believe a formal referral and a visit much earlier on would have benefited [Mrs A] and the staff at [the rest home].

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There is conflicting evidence in relation to advice.

Any other comments
Communication
Having read all the documentation provided, I wish to comment on the communication between the facility and the next of kin. [Mrs A's] NOK is listed as EPOA Health/Welfare — [Mr A] who was [Mrs A's] husband. Other NOK is listed as [Mr C] who lives in [another region].

Documentation showed that a meeting was held on the 8.7.2014 with [Mr A], stating that no confidential information is to be discussed with any of his children and is to be directed straight to [Mr A] himself and for the children to be told to talk to their father. It lists who was at the meeting.

Communication with family plays a vital role in ensuring that Family/NOK/Whānau are informed of the issues when loved ones are in Residential Care.

There is information in the nursing Progress Notes to show that [Mr A] did visit often, but there is little to no information to show that he was informed of his wife's sacrum pressure areas.

[Mr A], as [Mrs A's] NOK and EPOA had the right to be informed of the nature and the treatment of any wound and any medical issues that may have affected his wife.

I am of the opinion that it is unacceptable not to communicate and keep family informed.

I am of the opinion that communication was severely lacking and that [Mr A] was not informed of his wife's condition.

I also believe that this omission would be viewed as severe by my peers.

Jan Grant."

The following further advice was received from RN Grant:

"I have been asked to provide further expert advice on the care of [Mrs A].

My advice is given following a review of documentation provided. I have not spoken to or otherwise communicated with any affected party.

I have been provided with the following documents:

Response bundle from former Clinical Manager, [RN H].

Letter from [the DHB] dated 23rd September, 2016

Letter from [the medical centre] dated 20th September, 2016

Letter from [the rest home] dated 20th September, 2016

I have been asked to answer the following questions after reviewing the additional information.

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The appropriateness of the care provided to [Mrs A] by [RN H].

Having read the supporting information that has been provided, I am of the opinion that my initial opinion is still appropriate and I do not wish to change this. However, I would like to make additional comments after reading the new information provided.

[RN H] hours.
Evidence is presented on the hours worked, the on call requirements, and the responsibilities of the Clinical Manager's job.

It is very difficult for a nurse manager to be on call 24/7, and to ring in and follow up staff/patient needs when off sick. [RN H], in my opinion, worked excessively and did not have adequate time off. Professionally, this is inappropriate and unsafe to have occurred. All staff requires, and is entitled to, adequate time off. Employers have a responsibility under Health and Safety regulations to ensure that staff is given reasonable time off and that sick leave is respected. I understand that [RN H] felt a huge commitment to the facility, especially with the high turnover of staff lacking specific gerontology knowledge. The Clinical Manager's role is a challenging one, and becomes more so when there is the additional lack of appropriately qualified gerontology nurses to support the role.

I note that [RN H] personally paid for four staff members to attend educational sessions when the owner of the facility would not support education for the number of staff she wished to attend.

It is acknowledged through the number of references from members of the local community, including professional people, members of the public and the Māori people of the local Iwi, all hold [RN H] in very high regard. Theme of all the references is the commitment she gave to the facility and the care and respect she herself received from within the community.

I note that [RN H] acknowledges that she could have been more assertive in seeking an earlier review of the wound (67 of her personal statement) and that she could have made a formal request to the GP to personally examine the patient and actively participate in the treatment of the wound (54 of her personal statement).

The appropriateness of the changes made by [the rest home] since the time of these events.

Changes made to policy and procedures:
I have reviewed the new policies and procedures, which are in draft form, in relation to 'Wound Management Policy and Guidelines'. The new policies are robust and certainly outline the necessary information and the process needed to ensure a high standard of wound care. Input was gained from experienced nurses outside the organisation.

Documentation required to be completed in the event of patients having wounds, shows that there is to be a systematic follow up of non-healing wounds. The policy also clearly outlines the pathways by which responsibility needs to escalate should any staff member have concerns. Flow diagrams outline clear processes. Information in the policy is educational in nature and can be used as a resource for staff.

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Evidence is presented to show the commitment of the clinical review process. The quality improvement process identifies any issues and the actions completed.

I am of the opinion that [RN H] has made a very professional effort to prevent the same event from ever happening again. She has also personally initiated a healing process with the family.

Any other aspects of [Mrs A's] care that you consider warrant comment

As previously stated in my original brief, I remain of the opinion that [Mrs A] did not receive an adequate standard of care and that communication with family was poor.

Summary

I do, however, acknowledge the challenges and stress that [RN H] has gone through. Small rural facilities and communities pose a very different dynamic from larger, more formal environments, which have greater numbers of appropriately qualified aged care staff, and have easier access to specialist professional support.

Documentation, communication and professional standards should at all times be paramount in any interaction with patients and families. The changes made to the Wound Management Policy and Guidelines will assist the staff of [the rest home] to achieve these goals.

Jan Grant."

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Appendix B: In-house clinical advice to the Commissioner

The following expert advice was obtained from general practitioner Dr David Maplesden:

> "1. Thank you for the request that I provide clinical advice in relation to the complaint from the family of the late [Mrs A] about the care provided to her by [the rest home], visiting GPs [Dr I] and Dr J, and [the DHB]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: complaint documentation from members of [Mrs A's] family; response and care notes from [the rest home]; response from [the DHB] and [the public hospital] clinical notes; responses from [Drs I and J] and GP notes.
>
> 2. The complaint against [the rest home] relates to various aspects of [Mrs A's] nursing care, including that [Mrs A] developed pressure areas on her heels and sacrum while in [the rest home] and the wounds were poorly managed and contributed to [Mrs A's] death. This advice will address the role played by the named GPs in the management of [Mrs A's] pressure wounds with nursing advice to be provided by a nursing peer. The complaint against [the DHB] refers to concerns that [Mrs A] was discharged prematurely following an admission to [the public hospital] 11–12 [Month3] with sepsis, that DHB [NP K] did not view [Mrs A's] pressure areas prior to providing verbal management advice to [the rest home] staff, and that DHB staff were insensitive to the needs of [family] following [Mrs A's] sudden death in ED on 23 [Month4].
>
> 3. DHB response
>
> (i) [NP K] states she only ever received one referral by e-mail from [the] facility manager on 19 [Month4]. The referral noted deterioration in [Mrs A's] sacral pressure area, the pressure area having been present for three months. [NP K] contacted the facility manager by phone on 21 [Month4] to request further details and give verbal advice before she could schedule a visit to [the town] to view [Mrs A]. The facility manager agreed to provide further information (NHI and date of birth) so the initial referral could be processed appropriately but this information was not forthcoming. It was only when [NP K] made a follow-up enquiry by e-mail on 31 [Month4] that she was advised [Mrs A] was deceased. [NP K] notes that wound care *is considered part of the usual practice* of a RN and her team provides a specialist service which includes verbal advice and pre-scheduled wound reviews. The team does not have the capacity to perform immediate assessments of wounds, but had she been provided with the information requested a visit could have been scheduled for 23 [Month4].
>
> Comment: I have viewed a copy of the referral letter which is of reasonable quality but does not include any patient details (name, age, date of birth, NHI). The annotated advice given to the facility manager is comprehensive. Under the circumstances, and on the basis of the information provided in her response, I feel the initial management provided by [NP K] was appropriate and subsequent management was dependent on information provided by the facility manager which was not forthcoming. I note there is a significant discrepancy between [NP K]'s] response and that of the facility manager regarding extent of contact between the two (see 4(ii)) and I am unable to confirm the precise sequence of events in this regard. It may be that further information is required

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from [NP K] in relation to the information summarised in section 4(ii) regarding the stated contact between the facility manager and [NP K]. If further advice is sought from [NP K], she should be asked what records are kept by her of the verbal advice given regarding wound management for specific clients and what the expected process is for provision of such advice (eg is a formal written referral expected).

(ii) The DHB response I feel adequately addresses the perception by members of [Mrs A's] family that they felt pressured to leave the whānau room following [Mrs A's] death. I note staff guidelines are being developed to facilitate a culturally appropriate response to the dying or recently deceased patient in ED. I note that DHB staff have also met with members of [Mrs A's] family to discuss their issues face-to-face ([date]) with a written response provided on [date].

(iii) Infectious diseases specialist [Dr L] has provided a response to the complaint regarding [Mrs A's] discharge from [the public hospital] on 12 [Month3] following an overnight admission. [Mrs A] was assessed in ED immediately following her arrival by ambulance about 0405hrs on 11 [Month3]. A diagnosis of presumed urosepsis with secondary acute kidney injury was made on the basis of her clinical findings. She was noted to have sacral and heel pressure areas but these were not felt to be a likely source of infection. Due to her pre-morbid dependency and co-morbidities she was not felt to be a candidate for escalation of care to HDU or ITU. However, active treatment was commenced with IV fluid resuscitation and IV antibiotics and [Mrs A] was admitted to a medical ward. [Mrs A] responded well to treatment and by the morning of 12 [Month3] she was afebrile, normotensive and serum creatinine had markedly reduced indicating recovery from the acute kidney injury. [Dr L] spoke with [Mrs A's] husband on the morning of 12 [Month3] and he was in agreement with the plan for [Mrs A] to complete her recovery in [the rest home] given the level of care expected there (hospital level care). [Dr L] was confident that [rest home] staff would continue to appropriately manage [Mrs A's] pressure areas.

Comment: Clinical notes are consistent with the response. ED notes include: *L heel — 2cm radius ulcer, sloughy tissue. No pus. No surrounding erythema. R heel — healed ulcer, dry. Sacrum ulcer … not infective looking.* Discharge summary includes the comment that discharge on 12 [Month3] was *discussed with patient's family who are happy for [Mrs A] to be discharged.* GP instructions included review bloods in one week (form supplied to patient) and for use of antihypertensives (stopped in hospital) to be reviewed. Oral antibiotics were provided. Given [Mrs A's] rapid response to in-hospital treatment I think it was a reasonable decision to discharge her back to [the rest home] following discussion with family. Given [Mrs A] was receiving hospital level care, I think it was reasonable to assume that nursing surveillance would be adequate for her condition and that any deterioration in her condition would be promptly reported to her GP. It was also a reasonable expectation that nursing staff would manage [Mrs A's] pressure areas in an appropriate fashion and would refer her for wound specialist or GP assessment if there were concerns regarding healing.

4. With respect to involvement of GPs and [NP K] in the management of [Mrs A's] pressure ulcers, [the] facility manager has provided the following information in her response:

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(i) A blister on [Mrs A's] left heel was first noted on 13 [Month1] and a wound care plan was commenced. The wound was notified to [Dr I] who documented it on 16 [Month1]. By 9 [Month4] wound care documentation suggested there was improvement in the heel wounds. The wounds were thought to be due, at least in part, to the use of a brace (for foot drop) with ill-fitting shoes and provision of larger fitting shoes was discussed with [Mr A].

(ii) A small sacral split was first noted on 16 [Month1] and sacral area cares commenced. The wound would begin to heal then break down again. The respondent states a phone conversation was undertaken with [NP K] and the wound care plan faxed to her on 15 [Month2] with further information provided by scan and e-mail on 18 [Month2] although there was apparently no response from [NP K] to this information.

(iii) There were several attempts made to place a urinary catheter during [Month4] to try and enhance wound healing. This was achieved successfully on 9 [Month4] and resulted in improvement in perineal excoriation *and the sacral wound was showing improvement.*

(iv) [Mrs A] *was seen again by the GP [Dr I] on 16 [Month4] because the wound was not responding to the dressing plans we had in place and had started to become smelly. Calls to the Wound Care Specialist, including faxes and emails with the current wound care plans and asking for help did not come as soon as we wanted.* [Dr I] charted antibiotics.

(v) Dr J reviewed [Mrs A] on 20 [Month4] and advised contact with the Wound Care Specialist (WCS). [Mrs A] remained on antibiotics. The facility manager attempted to contact the WCS by phone on 20 [Month4] but was unsuccessful. On 21 [Month4] she called again and eventually made contact with [NP K] who provided verbal advice which was implemented immediately.

(vi) On 22 [Month4] [Mrs A] became increasingly unwell and [rest home] staff attempted to contact the facility manager for advice but were unable to do so (she was attending a [personal matter]). They finally made contact the following morning and the facility manager advised immediate transfer to [the public hospital] but sadly [Mrs A] died shortly after her arrival in ED. The facility manager notes staff should have been aware there was GP cover available on 22 [Month4] and should have sought clinical advice sooner than they did.

5. [Dr I] has provided a response dated [date]. The response includes the following points:

(i) [Dr I] attended [the rest home] regularly between 2006 and [Month3] when [Dr J] took over in this capacity, although she still provides cover for the facility when [Dr I] is on leave. There are scheduled GP attendances twice a week (Monday and Thursday mornings) and routine reviews are also undertaken on a one or three-monthly basis depending on the patient's level of care. Medical staff are available for unscheduled emergency visits and after-hours advice.

(ii) On 13 [Month1] [Dr I] provide [Mrs A's] routine monthly review and no particular concerns were noted. On 16 [Month1] [Dr I] was asked to review a blister on [Mrs A's]

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left heel which the RN felt was due to ill-fitting footwear. The blister was intact with no signs of infection and advice was to keep the area protected until it healed and to report any signs of infection. There was no mention of any sacral lesion at this time.

(iii) On 23 [Month1] [the rest home] staff requested [Dr I] place a urinary catheter as [Mrs A] was regularly incontinent of urine and it was felt the constant moisture was placing her sacral area at risk. There was no attention drawn to an actual sacral pressure area at this stage. The insertion was delayed until the ward round of 28 [Month1] but [Dr I] was unable to insert the catheter because of technical difficulties. At this ward round [Dr I] noted the blister on [Mrs A's] left heel was healing well but she had developed a pressure area on the right heel (no signs of infection). A recent right arm injury was reviewed. *The RN advised me* [the sacral pressure area] *was very small and I did not need to examine it … I advised the nursing staff that if any signs of infection were to develop then they should contact a doctor.* In the interim the sacral area was to be kept dry and pressure free by more frequent changing of pads and position.

(iv) Next review by [Dr I] was the regular monthly assessment on 14 [Month2] at which point staff reported that [Mrs A's] heels were healing well but the sacral pressure area was not improving despite current interventions described above. [Dr I] requested the facility manger make an urgent referral to [NP K]. She did not examine the sacral wound as she was under the impression [NP K] would be assessing the wound in the near future.

(v) [Dr I] was later informed by the facility manager that [NP K] had not physically examined the wound but had provided verbal advice on management and at routine monthly review on 4 [Month3] the RN reported the sacral wound was improving, largely as a consequence of keeping [Mrs A] in bed with frequent position changes rather than allowing her to sit for prolonged periods. On 8 [Month3] [Dr J] reviewed [Mrs A] in relation to a toenail issue and no concerns were noted on this occasion regarding the sacral pressure area.

(vi) On 15 [Month3] [Dr I] assessed [Mrs A] following her discharge from [the public hospital] (see 3(iii)). The course of antibiotics [Mrs A] had been prescribed on discharge was extended for a further week because of persistent respiratory symptoms but [Mrs A] appeared otherwise recovered. Renal function was checked as advised in the discharge summary and medication adjusted accordingly. *No concerns were reported regarding the sacral pressure sore at this time.*

(vii) [Dr I] reviewed [Mrs A] on 25 [Month3] after her husband reported her to be sleepier than usual. [Mrs A] appeared well and examination was unremarkable. *[the rest home] staff reported her heels and sacral pressure areas were continuing to heal, albeit slowly … I asked whether there were any signs of infection and was advised by the RN there was not. As such I did not consider there was an indication or need to examine them at this time.*

(viii) On 16 [Month4] [Dr I] was asked by [the rest home] to review [Mrs A's] sacral wound as it *had become smellier and they felt that she may be developing a small sinus in it.* [Mrs A] was reported as being well otherwise with normal observations including normal temperature. [Dr I] noted *a large sacral pressure area that had an offensive*

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smell. There was no surrounding redness or tenderness (no indication of surrounding cellulitis). [Dr I] prescribed a broad spectrum antibiotic and requested the facility manager make a further urgent referral to [NP K] to review the wound and provide expert advice on management.

(ix) On 24 [Month3] [Dr I] had met with the facility manager and owner to *discuss some concerns that [Dr J] and I had about the care of some patients at [the rest home], especially around communication and chronic wound management.* [Dr I] provided contact details for a wound care educator who could provide further education to facility staff. Methods to improve handover communication were discussed, as was provision of a computer so consultation notes could be entered directly into the GP PMS.

6. [Dr J] has provided a response dated 24 September 2015. His response includes the following points:

(i) [Dr J] saw [Mrs A] for the first time on 8 [Month3] at the request of her husband who was concerned at the appearance of his wife's toenails. Clinical diagnosis was likely fungal infection and a conservative approach to management was considered appropriate. [Dr J] does not recall being advised of any concerns regarding [Mrs A's] pressure areas.

(ii) On 29 [Month3] [Dr J] was asked to review [Mrs A] in regard to her heel pressure sores and right ear discharge. The heels *showed skin breakdown but no clinical signs of infection.* [Dr J] advised continued care as per the documented care plan. He was aware from [Dr I's] recent consultation notes that [Mrs A] had a sacral pressure area (see 5(vii)) but no concerns were raised by staff regarding this.

(iii) At routine monthly review on 6 [Month4] [rest home] staff expressed concern that [Mrs A's] urinary incontinence was interfering with healing of her sacral pressure area (a catheter had been inserted but then removed during the [the public hospital] admission in mid-[Month3] and previous attempts to re-insert it had been unsuccessful). [Dr J] advised continued pressure area cares as per the current plan, and that he would discuss with [Dr I] regarding re-catheterising [Mrs A]. Before the discussion took place, [rest home] staff managed to successfully re-catheterise [Mrs A] (9 [Month4]). On reflection, [Dr J] states he should have viewed [Mrs A's] sacral wound on this occasion to satisfy himself it was not infected, and this would be his usual practice. However, he was somewhat distracted by the catheterisation issue and was aware facility staff were closely monitoring [Mrs A's] wounds and would notify him if there were specific concerns.

(iv) On 20 [Month4] [Dr J] reviewed [Mrs A's] sacral pressure wound. She was part way through a course of oral antibiotics prescribed by [Dr I] (see 5(viii)). *I observed the sacral wound was large and deep with some necrotic tissue but no infection. I instructed [the rest home] manger to liaise with [NP K] … on further management of the wound then to discuss the plan with me … I recall [Mrs A] appeared clinically well during the consult.*

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(v) [Dr J] states: *On 23 [Month4] I was called urgently to [the rest home] to review [Mrs A]. I noted that [Mrs A] had been unwell since the night before (feverish, reduced consciousness and not eating/drinking). On examination I determined that clinically she was septic and arranged an immediate transfer to the hospital via ambulance in consultation with* [Mr A].

7. I have reviewed the GP notes (practice PMS) and these are of reasonable quality. The content of the responses is consistent with the contemporaneous clinical notes.

8. I have reviewed [the rest home] care notes. GP notes are copies of those recorded in the practice PMS. Additional comments include:

(i) There is a handwritten sheet on which a [rest home] staff member has recorded contact with [NP K] on the following dates: 14 [Month2] (telephone call, verbal management advice recorded); 16 [Month2] (*call to [NP K] to come, no reply, left msg, continue with current plan*; 18 [Month2] (*scanned, e-mailed c/plan to [NP K])*; 22 [Month4] (*1130 called [NP K]).* There is also a record of e-mail contact and written referral to [NP K] dated 19 [Month4] (see 3(i)).

(ii) There are comprehensive wound care plan notes for the heel wounds dated from 14 [Month1]. The comment in the 'Outcome' portion of the wound care plan is almost exclusively 'healing' or 'slowly healing' up to the point of [Mrs A's] final admission to [the public hospital]. There is no particular sense of concern at overall healing or signs of infection demonstrated from the wound care plan.

(iii) There are comprehensive wound care plan notes for the sacral wound dated from 17 [Month1]. Notes suggest there was slow healing of the wound until around 13/14 [Month2] when deterioration was noted secondary to the wound being moist, although there were no signs of infection. The management plan was changed on 14 [Month2], presumably in response to the advice sought from [NP K]. The wound was described as 'slow healing' or 'delayed healing' until early [Month3] when there are several comments that it is 'healing well'. From 8 [Month3] comments predominantly relate to 'slow healing' although a consistent comment is that there is no sign of infection. On 6 [Month4] there are no particular concerns noted regarding the wound (*The wounds were looking better and the surrounding skin were looking better. No other problems*) although from 7 [Month4] the wound apparently began to enlarge with breakdown of the surrounding skin. Offensive smell was noted from 11 [Month4] and there appears to have been gradual deterioration of the wound from this time despite prescription of antibiotics.

(iv) On review of nursing/care notes it appears [Mrs A] was eating and drinking well on 19 [Month4] with no concerns noted during 20 [Month4] other than refusal of dinner. [Mrs A] appeared sleepy during the afternoon shift of 21 [Month4] but apparently had an uneventful night. The sacral wound was felt to be 'worsening' on the morning of 22 [Month4] but [Mrs A] was eating and *no other concerns.* During the afternoon shift that day [Mrs A's] food and fluid intake decreased and she was noted to be drowsy. [Mr A] was concerned and requested his wife be reviewed by the GP the next day. [Mrs A] was febrile (39.1) at 2015hrs and was given paracetamol and tepid sponging. Frequent recordings over the next three hours showed persistent fever and a degree of hypotension although no tachycardia. At 2230hrs oxygen saturations dropped to 87%

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and oxygen was commenced. Urinalysis was negative and a message was left on the manager's cellphone 'for triage' with no response received. Observations were continued overnight and were relatively stable although [Mrs A] remained hypotensive. At 0800hrs a visit was requested from the GP and he attended around 1100hrs and arranged [Mrs A's] admission to [the public hospital].

8. Comments on the GP role in the management of [Mrs A's] pressure areas

(i) As noted by [NP K], wound management skills are an expected part of a registered nurse's scope of practice and in my experience nurses generally have a better understanding of the variety, properties and indications for use of the specialised dressing materials available than many GPs. Nursing staff would also be expected to have the skills to independently perform a pressure area risk assessment and to implement an appropriate pressure area prevention or treatment plan. GP intervention would generally be warranted if there were complications noted in wound healing, and particularly if it was felt the wound was infected or required formal debridement. In a rest home environment, it is expected practice that registered nursing staff will bring any concerns regarding wound healing to the attention of the visiting clinician rather than wounds being routinely reviewed at every attendance. If a wound was causing concern, it would be expected that specific concerns are brought to the attention of the visiting clinician and the wound is available for inspection (ie dressings have been taken down) prior to scheduled clinician review.

(ii) There were two occasions when, with the benefit of hindsight, clinician review of [Mrs A's] sacral wound might have been indicated. These were 14 [Month2] ([Dr I]) and 6 [Month4] ([Dr J]). However, on 14 [Month2] documented nursing concerns related to recent lack of progress in healing of the wound with no signs of infection (rather than any significant deterioration, and the wound was evidently not available for inspection when [Dr I] undertook her review. [Dr I] gave appropriate advice, quite reasonably expecting that a WCS would be examining the wound in the near future. There was no subsequent discussion with her regarding the fact that only verbal advice had been obtained from the WCS. With respect to [Dr J's] consultation, there is no indication he was asked by nursing staff to specifically review the wound, the wound was evidently not 'undressed' ready for inspection, and contemporaneous wound care notes suggest the wound was actually improving somewhat at this particular time (after a period of slow healing) with no signs of infection. Under the circumstances, I would not regard the failure by either doctor to physically review [Mrs A's] sacral wound on these occasions to represent a significant departure from expected standards, nor do I feel that her management plan is likely to have altered on these occasion even had the wound been reviewed.

(iii) I am satisfied that [Mrs A's] overall management by her GPs was appropriate to the information provided to them by [the rest home] staff and management and to their observations of [Mrs A] on the occasions she was reviewed. There may well have been some deficiency in the quality and timeliness of information provided to the GPs by nursing and management staff and a nursing peer would be best placed to comment on aspects of [Mrs A's] nursing management and the additional nursing issues raised in the complaint."

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